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CORNER

LAST night, when George Winter and Clarence Simpson —two highly prized customers of this word bazaar— were in Pittsburgh to spellbind the local boys, this department sat on a hard chair in the second row and learned precious little about radiodontic examinations and exodontia.

(At this point, George and Clarence, perhaps at the very moment you are reading these lines, have just started to read them, and are beginning to brew rages. This would be a pity because no criticism is meant at all. This is just the preamble to a tribute they deserve, and the impulse to pay that tribute is so lively and strong that this CORNER is being written the next morning, on Sunday, and, wonder of wonders, a full month before the deadline.)

It should have been easy to learn about exodontia and radiodontia. The Old Master's new clinical motion picture is wonderful. And his companion, the St. Louis Will Rogers, is always so lucid (and entertaining) that it should not have been difficult to comprehend him.

But this department's mind wandered again and again. The thing I was thinking of, most of the time, was the

humility of these two men, and their humble approach to their subjects, and their complete and entire freedom from any all-wise posing—their insistence, in fact, that they don't know it all, and are still seeking and studying, trying to learn more about those departments of science to which they have devoted the best part of their lives.

One slide of Clarence Simpson's actually illustrated an error in diagnosis he had made, not, he said, because the case was so baffling, but because he had been careless, had been inattentive, had not devoted sufficient time to studying the first films.

How often we listen to men swollen to vast proportions by a little learning, men who have developed some special facility in their work, or originated new technics. Each builds for himself a mental Olympus, a mental mountain upon which he sits and from which he voices his findings with an air of complete and utter finality. His methods are the last word in the book and the book is closed. Perhaps he *has* contributed something very valuable. But there he stops, forgetting that man is incapable of perfection—that there is always another chapter.

Looking at George Winter's pictures, and listening to him, I recalled something he had said that afternoon while we were walking. "Someone in China might be able to teach me something new about exodontia. I wouldn't be honest with myself or my patients if I didn't go over there to learn about it."

The China to which he figuratively referred is, with most of us, often just around the corner, or down the hall.

Last night, as I sat there on that hard chair, I thought:

Here are two men whose fame has girdled the globe. In every country their work is known and respected. The profession believes they have their specialties bound and gagged and strait-jacketed.

They are believed to have finished, to have arrived, to be resting on their well-earned laurels, idly puffing at their cigarettes while they complacently look back on long years of achievement.

Thousands and thousands of men believe that about George Winter and Clarence Simpson. But George and Clarence don't believe it about themselves.

Hats off, they still stand at the feet of Science, and will until they die.

It is as though, penetrating a little way into a forest that first seemed just a group of trees, they have gone on and on ahead of the others who stopped, satisfied, in the first grove. They have gone on and on and discovered a vast domain, tangled wildwood, virgin timber of strange species, plant life of complex forms.

Putting much of the forest behind them, far outdistancing those who entered it with them, they have concluded that it is all so vast they will never know all about it—however zealous and patient and laborious their devotion to research.

And so they are humble, humble in their tireless pursuit of new truths, humble when they share their knowledge with their fellows.

That is what I was thinking about last night, sitting on that hard chair in the second row.

JUNE, 1934 • VOLUME 24, NUMBER 6

(CONTINUED ON PAGE 823)

(CONTINUED FROM PAGE 820)

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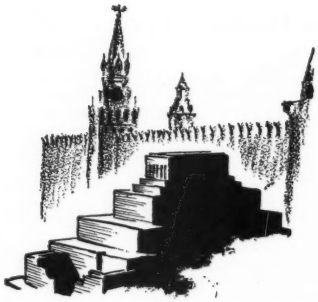
What One Dentist Saw in RUSSIA



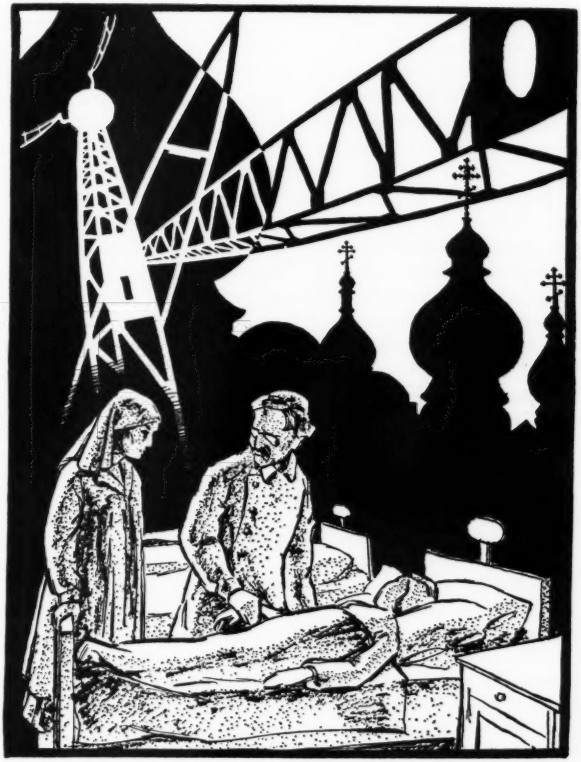
Lenin's tomb and the walls of the Kremlin.

By R. A. MARSH, D.D.S.

WHICH road will dentistry take in this country? What road has it taken in other countries? These are two of the questions for which we have been seeking answers in these past few years. We have read many articles in ORAL HYGIENE and other dental journals on socialized, panel, and State dentistry. Through the newspapers popular columnists have given us their ideas on these subjects.

Writers of high standing in the dental profession favor a new system whereby the public may receive needed dental attention and the dentists may receive an assured income. They propose to bring this about through insurance plans. Some would like to see a direct tax levied like the poll tax, and there are some who sincerely believe we should all be on the Government payroll.

Since the advent of the New Deal every business and industry is receiving Government aid. The banks and railroads have the RFC; the farmers have the AAA; and others have the CCC and PWA. Why, some ask, should not the dentist come in for his share of aid? The majority of the writers and most dentists seem to be of the opinion that we should fight every effort of our own numbers and of the Government to create a Frankenstein that would destroy the high standards attained by American dentistry after a half century of struggle. Only temporary emergency measures are needed, some men have argued; the good old days will surely come back again, and then everyone will be happy.



"Fine new hospitals have been built everywhere."

With thoughts like these in mind I sailed for Russia last year on the fifteenth of July. There, I thought I would find State dentistry in its extreme form with the dentists living in a kind of Utopia free from all worry and economic changes, while we, in this country, were going to the proverbial bow-wows. In England, I disembarked from a luxurious French liner to board a small Soviet steamer, bound for the land of the new order. Flying the small Red flag emblazoned with the sickle and hammer and manned by a trim crew of young men and women, it was a little unlike any foreign ship. There were only second and third class quarters on board. True, these same quarters could have been called first and second class, but, of course, first class smacked of the bourgeois

class; hence, it could not be tolerated on a Red ship.

The food was good but plain; the few bathrooms were uninviting; hot water was scarce—the steward explaining that they needed all the hot water for cooking and washing dishes. Among the passengers were a physician, several lawyers, teachers, college students, and a good number of American Communists, several of whom were being deported from this country. There were others returning voluntarily to make their permanent residence in Russia. It was a happy group; we sang the Internationale to the delight of the Russian crew, who reciprocated in the evenings by entertaining the passengers with folk songs and native dances. The weather was ideal, and the sea smooth as glass. Five days after leaving London we arrived in Leningrad, once called St. Petersburg, then Petrograd, the old capital of Russia. Since we were traveling northward the days had been getting longer. In Leningrad, it was twilight at eleven o'clock and not quite dark at midnight. These were the Bella Noche, the Russian name for beautiful nights. Further north is the land of the Midnight Sun where for several months during the year the sun does not sink below the horizon.

The customs regulations of the Soviet Union are probably the strictest in the world. Only a limited amount of wearing apparel can be taken into the country. A man may carry only men's clothing in his baggage, and a woman may carry only women's clothing. Money and checks are examined and counted by an official and entered on a document, a copy of which is given the owner. When leaving Russia this copy must be presented at the point of exit to a customs official who again counts the tourist's money and checks, if he has any left. Incidentally, no one can take Russian money into Russia nor take it out when leaving the country.

Soviet finance and exchange are very puzzling to the layman's mind. In foreign countries one can buy many rubles, sometimes as many as one hundred for a dollar. But once in Soviet territory, the law forbids any one to exchange more than one and one-half rubles for a good American dollar. Rubles are plentiful and cheap for the native citizens; perhaps this accounted for the scarcity of toilet paper in the hotels, the paper being needed for printing rubles. Many travelers, advised beforehand, carried rolls of this paper in their baggage.

The procedure at the customhouse took many hours, and some of the visiting Communists began to get lukewarm in their enthusiasm and wished they were back in the good old USA. But the Government must protect itself against imports which would enable us or any other

"The State begins early to supervise the life of each child."

visitors to speculate and make huge profits. Young women employees at the customhouse entertained at the piano during lunch hour, playing such popular numbers as "Yes Sir, She's My Baby," "Tea For Two," and "Hot Cha Cha." Feeling the spirit of the country we were approaching, some one asked her to play the Volga Boatman. She explained through an interpreter that she had not yet heard this new song. For the first time, we heard a Russian here talking on the telephone. Several of us agreed that, should the windows be opened, no wires would be needed for the listener at the other end of the line.

NEW BUILDINGS GOING UP

There is extensive building going on in the largest cities, principally in Moscow. New factories, hotels, apartment buildings, and subways are un-

der construction. The art galleries, museums, and royal palaces have all been preserved, and nothing of cultural value has been destroyed just because it belonged to the old regime.

Keeping pace with the industrial expansion are the new social reforms and public health activities. Nowhere in the world has the Government taken a hand in public welfare as it has here. Fine new hospitals have been built everywhere. There are hospitals for expectant mothers and special institutions for the treatment and rehabilitation of prostitutes. Modern nurseries under trained supervision are maintained at every factory where mothers work.

Prison reforms seem unbelievable. Prisoners are not locked in their cells, but are treated as patients. They are given vacations to enable them to visit their homes for a week or two each year during their period of incarceration. Political prisoners, however, do not fare so well; for any crime against the state, such as sabotage, stealing or burning grain, or plotting a counter-revolution, a Russian is shot after a secret trial.

The marriage ceremony is a simple affair; a couple appear at a registry office, sign their names, pay a few rubles, and the wedding is over. If tomorrow morning the husband doesn't like the way his new wife has prepared the toast, he can stop in the same office, ask for a divorce, and pay a few more rubles. There are no reasons to be given or questions asked. In the afternoon mail, the wife gets her copy of the decree telling her that her husband is once again a free man. Of course, in a marriage where there are children or a sick partner, it is not so simple, as alimony then enters the picture.

A word as to the churches and religion! The Government merely withdrew support from the clergy and levied heavy taxes on the churches making it impossible to maintain organized religion. It is illegal to teach the child religion at home or in any school.

There is very little private business being conducted in Russia today, and every profession and trade has been organized to conform to the new economic system. Since individualism has no place in the new order, dentistry is on the same plane as other trades and professions. *A dentist is in the same classification as a mechanic.* The technical man and the engineer are the men with some standing in the new aristocracy. Private practice of dentistry is still being conducted by the older men who were in practice before the revolution. But theirs is a hard life; they have oppressive taxes to pay and are unable to obtain needed supplies. Private practice will disappear altogether with the death of these men, and the young growing up and imbued with the new ideas will take their places, not in private offices of their own, but in clinics

and infirmaries, working with other young men and women. It's just like going to dental school all through life.

STATE SUPERVISES CHILDREN

The State begins early to supervise the life of each child, even before birth, at the prenatal clinics I have mentioned before. Then come supervised nurseries, schools, and playgrounds. The children teach their elders, hence parental authority is nil. When a young man or woman desires to study dentistry, he takes up his subject because he likes it, and he proves to the authorities he is qualified to make this his life work. After graduation, he goes to work the same as any other office worker or mechanic. He has a six hour day, a five day week, has sickness insurance, and is provided with an annual vacation, the time given depending on his length of service and age. He can spend his vacation at home, go to the country, or travel to a Black Sea resort. He is paid while going through dental college and receives money con-

Royal gardens of the Peterhof have been turned into playgrounds for Russian children.

tinually from the State until he dies. It all sounded very fine to me in these trying days of depression.

The young men, however, are not as interested in dentistry as are the young women, of whom there are many in practice or rather working in the dental corps. The young men would rather be engineers and aviators than listen to patients telling about their aches and pains. Perhaps they are influenced, too, by the fact that the pay of a dentist does not compare favorably with that of an engineer. When I reminded one dentist that his pay was the same as that of a man I had talked to the day previous in a lathe plant, he smiled, said he was doing the work he liked and besides money didn't matter as he couldn't use it anyway. Because I told some of the dentists the cost of dental education in America and of entering practice and the difficulties encountered, they felt rather sorry for us.

Owing to the shortage of food, which is rationed, only men doing hard manual labor eat meat regularly. The dentists and other professional men, being in the white collar class, rarely see meat. They are poorly dressed and emaciated looking, but they smilingly tell you how happy they are. Meanwhile, they wait for better days to come. They are living in a world quite different from ours. They have never heard of a constitution; nor have they known prosperity. Liberty, freedom, and the pursuit of happiness are just empty words to them. What spirit these men and women have! They are a fine lot of human beings and a great credit to their country, right or wrong, in its great economic experiment.

Demand For Physicians and Dentists

There is much need for physicians and dentists. Consequently, the courses of study are not long, and the graduates are turned out "green," as compared with ours. An American engineer living there told me he hoped he would never need an emergency operation. Some eager embryo surgeon might be called in to operate—perhaps his first surgical case. A surgeon has to start somewhere.

The system of examining the patients, the care and treatment of the oral surgery cases, the hospitalization of dental patients are too lengthy to discuss in this article. One thing is certain, it takes a long time to get anything done. The matter of a few fillings may require a period of weeks before the work is completed. After all, there is no need for hurry or speed; there is no money to collect from the patient; nor is there rent to pay or installments on equipment to meet. The public must suffer in silence; they have to like it or else go without dental services. The few remaining private practitioners I spoke of are able

to do only a limited amount of work, owing to the scarcity of materials they need. Besides, the patient has no choice in this matter of selection.

Vulcanite dentures are made for the edentulous patients. The clasps and bars of partials are made of a stainless steel. Crowns and bridgework are also made of this steel. When I saw people on the street with these white crowns I thought they were made of platinum, as Russia has the world's largest supply of this precious metal. Dentists and laboratory men assured me this metal would not tarnish in the mouth and said it was a special alloy their engineers had invented for dental use. However, it was much like the stainless steels that have been introduced into the United States these past few years. The nobles and wealthy who fled from the country after the revolution took most of the gold with them, leaving none for the new Government to back the currency or for commercial use. Hence, the dentists were forced to find a substitute.

In a tremendous social upheaval such as has taken place in Russia, there are many changing scenes. Through the process of trial and error, they do not hesitate to develop and change plans. Perhaps, some of the conditions I saw no longer exist. It is impossible to report accurately, as every plan is an experiment on trial and may not be a permanent policy.

The Russians boast of a classless society, yet they have a privileged class and a number of underprivileged classes and some with no classification at all. The workers stand at the head of the list; they are in control, and all the benefits I have spoken of—work, health, and recreation—are for them. How the former clergy, members of the remaining bourgeois class and the White Russians obtain food, I am unable to state. As to dentistry for these underprivileged classes, well, they probably don't need any.

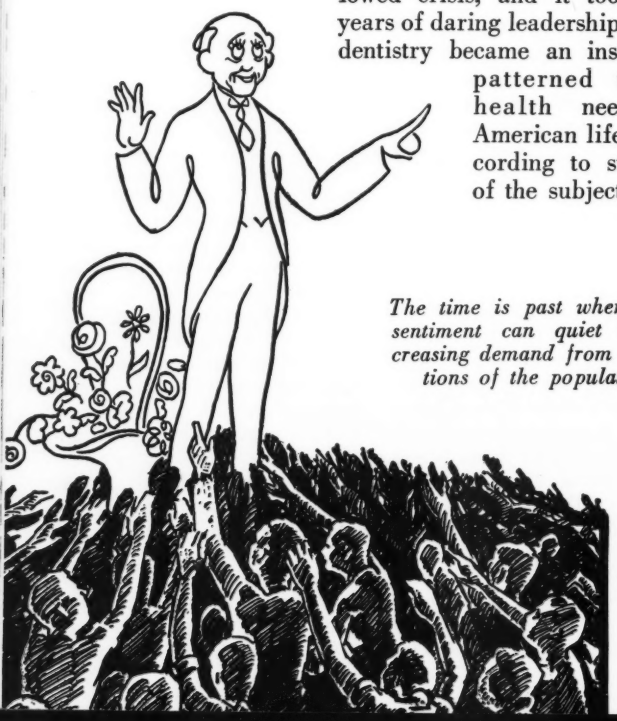
After three weeks under the Red flag, I was anxious to leave. During this time I had tasted little water; the safest thing to drink was hot tea; and the weather was very hot in Moscow in July. It all seemed like a topsy-turvy land. They treated us hospitably and evidently were anxious for American recognition. We ate caviar every day (if we liked it). Big strawberries with cream, and meat were also plentiful for us yet we knew that Russians were starving in the streets while we feasted. When the train reached Warsaw, twenty-seven hours after leaving Moscow, we all breathed sighs of relief, for somehow the air seemed so much clearer and freer.

Brookville, Pennsylvania

Can "OLD-DEALERS" Give Us a NEW DEAL?

By HERBERT E. PHILLIPS, D.D.S.

OLD, fixed habits of behavior or procedure are hard to change. This is just as true of institutions as of individuals. One hundred years ago our pioneer ancestors started the organization that has resulted in the institution of dentistry as we know it today. During its formative years, crisis followed crisis, and it took long years of daring leadership before dentistry became an institution patterned to the health needs of American life. According to students of the subject, insti-



The time is past when senile sentiment can quiet the increasing demand from all sections of the population.

tutions develop to meet certain needs and demands in social and economic life. They have an early period of growth during which basic policies are formulated and patterns of adaptation created. Following this period comes a plateau of usefulness in which patterns and policies become fixed and stable. This status quo remains until *new needs* and *demands* press the old institutions to adapt themselves or pass from the scene.

The institution of dentistry has been for several decades on the plateau of stability. For many years, no serious crisis has threatened its existence, and routine procedure during this relatively quiescent, comparatively "comfortable" period has proved successful in achieving our present status. Membership in societies has increased, and the scientific programs have grown in both scope and interest.

The inner political life of organized dentistry requires officials to carry out policies and procedures and dental schools and fraternities have to a large degree contributed their prominent members to our official families. These officials, collectively, are largely responsible for the policies that determine organization activities. With a few notable exceptions, such officials have given honest but conservative leadership. The majority of the rank and file have applauded this leadership and have given loyal and whole-hearted support.

NEW PROBLEMS CREATE UNREST

Within recent years, however, social and economic forces have brought new problems which are ignored by many of our officers. Criticism is heard and the volume seems to be increasing. For a while it was possible to dismiss this criticism with the explanation that there are always chronic kickers and malcontents.

This did not stop the critics who continued to pull at the official coat tails and point to the clouds on the horizon. Old terms of opprobrium were pulled off the shelf, and critics were referred to as communists, socialists, advocates of clinics and State dentistry—"evil spirits" leading the profession astray.

Meanwhile, the cloud grew larger and, as the depression increased, social and economic trends were accelerated. Commercial, industrial, lay, and government groups intensified their interest in health service. New problems of delivering and paying for health service stared the organized profession in the face. Many of our conservative leaders—cynical, smug, satisfied—advised against preparation. "Stand pat," they said, "it will blow over." Meanwhile, swift driving social currents have quickened the trends and have placed the professions in the center of the fast moving stream where rocks or shoals may wreck the professional craft and wash overboard the traditions and values accumulated during the past century. All this may happen before the quiet waters of a stabilized civilization are reached. The officers and crew are, at present, unaware of the currents and know not where to look for rocks and shoals. Unless these officials are prodded to study social navigation, we may have to say farewell to the values so gloriously won by our visioned pioneer leaders. These values are the framework on which the professions must depend for their social and economic status in the future and must be the basis for any new method of paying for or delivering dentistry. Their loss would mean a degraded health service to the public and a loss of both social and economic status to the practitioners. In the judgment of many, a New Deal is the answer.

Our professional and economic status is at stake. We must develop plans whereby the needs of millions of neglected families in the United States will be cared for and adequate remuneration will be provided for the professions whose members give the required services. These persons are entitled to the health care we are trained to give. The President of the United States requested that professional plans be developed to give them dental care. Our leaders, practiced in the maintenance of status quo, conservative by training and crystallized by habit, evaded the request by telegraphing "sweet nothings" in reply. The time is past when senile sentiment can answer a virile executive's request or quiet the increasing demand from all sections of the population. Status quo is obsolete.

Our membership, which at one time included between fifty and sixty per cent of all dentists, is decreasing. Yet, in view of the immense social and economic changes taking place, there is now imperative need for unity of thought and action. A large mass of dentists outside of organized dentistry, under the stress and strain of our unsettled times, are potential members of an economic dental organization[1] which may, under certain conditions, supplant for a time our present scientific association. Unorganized and unaffiliated dentists in sore need of leadership should, by some form of membership or affiliation, be gathered under the leadership of the organized ranks. Here unity of thought and action may gear them efficiently to a united effort for professional security, a security so essential in the delivering of health service to the community. So a New Deal is called for and, as youth is not crystallized and brittle in its thinking, is not bound by habit, is not afraid of that which is new, we call on youth for action. Youth has the drive of idealism and the love for adventuring. The future belongs to youth and the present offers responsibility and opportunity.

If two or three young men in each local society would take some of their leisure time to read and study the articles and books written on current social change[2] and its relation to health service, they would in a short while become informed on the subject. They should study the reasons for non-membership of ethical dentists by actually acquainting themselves with the thought processes of the unaffiliated. With this knowledge they will be equipped to consider intelligently ways and means by which the unorganized may be induced to join with the organized in meeting their common problems. These informed young men could then discuss with their local confreres their findings and, together, they could formulate policies and develop ideas. Supported by their intelligence and understanding, they would be in a position to approach and demand action from local, state, and national officials, in-

[1]In some European countries economic organizations of physicians or dentists have more members than the scientific organizations. The Hartman-Bund in Germany is an example.

[2]The J.A.D.A. will soon publish a bibliography of books and articles on this subject.

cluding the members of the house of delegates and the trustees. Opportunity would thus be given for present incumbents in state and national bodies to either inform themselves and move forward in step with the times or to step out and let those who respond to the spirit of youth and the needs of the times take a hand at the throttle.

It is more than probable, however, that the conservatives will protest and object, and the young men, though firm in their demands, should also be tolerant and kindly to those they displace.[3] If the youth of dentistry will apply themselves scientifically to the solution of present problems, our profession can face the future with the certainty that the institution of dentistry will adapt itself to the new times and our upward march will continue.

The great men of dentistry have been scientists using the scientific method. Every person who contributes informed, scientific leadership to his profession and the public in its present need can claim inspiration from and a feeling of union with the great and noble in our hall of fame.

5427 Ashland Avenue
Chicago, Illinois

[3]Anyone, regardless of age, who possesses the spirit of youth is included in this category.

DESTROYING THE CHILD'S FEAR

The suggestion that a child, from the time he is 2 years of age, should be taken occasionally to visit the dentist's office to destroy his fear of the surroundings before he experiences his first toothache was approved at a round-table discussion held at the last annual meeting of the New York Dental Society, New York City.

Doctor Waite A. Cotton acted as chairman of the symposium. Doctor Russell W. Bunting, of the University of Michigan, who led the discussion, emphasized the importance of the dentist making a pleasant impression on the child by substituting toys for the gleaming instruments he usually holds. Further, he urged that parents avoid frightening children by referring to the dentist as a "bogeyman" to enforce obedience and by refraining from discussing their own painful dental experiences—the result of neglecting their own teeth.

DIET *and* DENTAL CARIES *discussed at* CHICAGO MEETING

TWO distinguished scientists appeared before the scientific meeting of the Chicago Dental Society at the Stevens Hotel, Chicago, on April 17, to present illustrated lectures of unusual significance on the phenomena of digestion and the relation of diet to the cause of dental caries. Doctor Arno B. Luckhardt, of the University of Chicago, offered an interesting group of slides and motion pictures to illustrate his subject, THE PHENOMENA OF DIGESTION—ITS FUNDAMENTAL FACTORS AND FUNCTIONS. As a basis for the study of diet, he showed several charts on which stomach contractions were graphically recorded to demonstrate the mechanics of hunger. Following his presentation, Doctor Martha Koehne, of the University of Michigan, gave a comprehensive report on RECENT STUDIES OF THE RELATION OF FOOD AND OF CERTAIN METABOLIC PROCESSES TO THE CAUSE OF DENTAL CARIES.

Findings reported by Doctor Koehne were based upon intensive studies of the incidence of dental caries among four groups of children living under different conditions. Children attending a consolidated school in a rural section, a group in an Ann Arbor school, children in an orphanage, and a hospital group were observed over periods ranging from a few months to six or seven years in the case of the orphan-

age children. In some instances the home diets of the children were studied for data, and in others special diets were followed regularly and results as related to dental caries recorded.

Particularly significant were the findings on the relation between the amount of calcium and phosphorus present and susceptibility to dental caries. Speaking of studies made in this connection by Doctor Russell W. Bunting, herself, and others, Doctor Koehne said:

"We have been forced to conclude that resistance or susceptibility to caries bears no specific relation either to the calcium and phosphorus content of blood serum or saliva, or to their acid-neutralizing power. As a result of our studies we believe that, under conditions of ordinary health, the composition of saliva as related to these constituents fluctuates only within a narrow range with changes in diet."

Contrary to the opinion accepted by many that a well-balanced diet controls or inhibits caries, Doctor Koehne said she and her associates had collected evidence in their studies of the hospital group to show "that caries was produced in children eating diets generally recognized as satisfactory for normal growth and well-being."

On the other hand, Doctor Koehne pointed out that children living in the orphanage on a diet that was not adequate, as far as accepted nutritional standards go, were singularly free from caries. She also emphasized the fact that forty to forty-five per cent of the calories in this diet were derived from starch, for the most part from cereals.

As to a possible connection between stunted growth and dental caries, Doctor Koehne reported that the evidence obtained by studying the height and weight records of more than two hundred children in the orphanage showed that there was "no correlation between the height and weight status of the children and their susceptibility to this disease."

Tests for the presence of *Bacillus acidophilus* revealed some interesting and important data, according to Doctor Koehne. Saliva tests conducted in both the hospital and orphanage groups revealed no *Bacillus acidophilus* in the case of a small number of children, she said. These same children's teeth were free from cavities, even though, in some instances, their diets had been inadequate nutritionally. Apparently these children were immune to dental caries, Doctor Koehne said, and *Bacillus acidophilus* seemed unable to grow, even after repeated inoculations.

Continuing her discussion of immunity, Doctor Koehne stated that she did not consider the Eskimo a true immune, because when he changes from his primitive to our modern diet his teeth decay.

"We wish to emphasize," Doctor Koehne asserted in conclusion, "that probably no

single principle can be applied equally well to all persons in the prevention of tooth decay. There are some, undoubtedly, who are immune to this disease. It probably makes no difference what such persons eat, unless, perchance, some serious illness or metabolic disturbance causes this immunity to disappear. We are unable to explain the nature of true immunity. It may be due to conditions which determine the inherent ability of *Bacillus acidophilus* to thrive in the body, and is probably hereditary. There are also some persons who are so susceptible that the disease cannot be checked by adherence to an ordinary type of diet that fulfills all nutritional requirements, even if it contains restricted amounts of sweet food. The majority of those who are moderately susceptible to caries would, however, probably be protected in large part by adherence to diets that are low in artificially sweetened food."

Editor's Note: For those readers of ORAL HYGIENE who are interested in the detailed scientific reports of these studies, the following references are given:

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FORM BRONX ALLIED DENTAL ECONOMIC CHAPTERS

A new organization to be known as the Bronx Allied Dental Economic Chapters was formed recently in New York City for the purpose of establishing minimum fees, maximum office hours, and to devise means to combat commercialized dental clinics and other factors detrimental to the dental profession.

To form the basis for the organization, the Bronx was divided into geographical units or sections, according to the number of dentists practicing in that area. Each unit was then designed as a chapter. Forty to fifty members were enrolled in each chapter, the idea of this method being to keep the group small enough to permit an intimate understanding of each others' problems and promote a feeling of good fellowship.

These chapters function as autonomous organizations. Yet all are allied to form a central body known as the Executive Board of the Allied Chapters which consists of two members from each chapter. Thus the chapters can act in unison in matters pertaining to general economic problems.

Notes on the art of
EXODONTIA

By SETH W. SHIELDS, D.D.S.

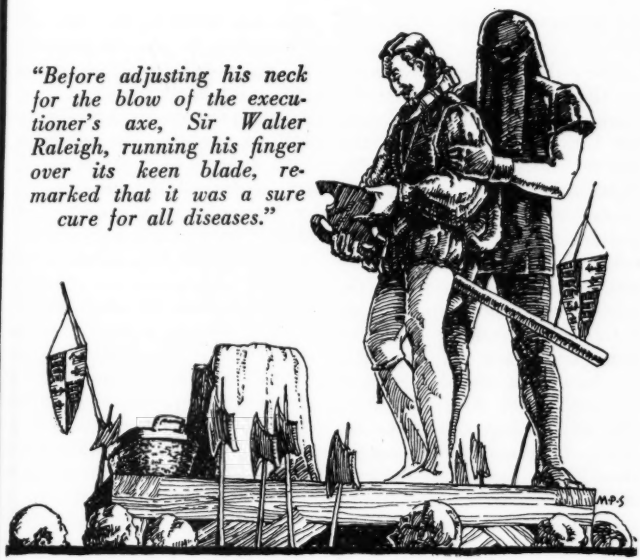
THE extraction of a tooth seems to be one of the most dreaded of all surgical procedures in the practice of medicine or dentistry. We hear from our patients time after time how, on account of fear, they have postponed their visits; and we have listened with patience while they related tales of dental woe concerning themselves, their relatives, and their acquaintances.

Patients who take the chair expressing confidence in what is to happen are in the minority. This indicates to me that there must be some justifiable reason for the apprehensive attitude of the majority who consult us in all the various stages of fright.

I wish to present some of the factors pertaining to exodontia, the application of which, in many instances, produced gratifying results. Variations must be made. of course, to suit different cases, and one hundred per cent success is not to be expected. No work that depends upon human skill can be perfect in every instance.

Before adjusting his neck for the blow of the executioner's axe, Sir Walter Raleigh, running his finger over its keen blade, remarked that it was a sure cure for all diseases. The jokes and cartoons; the light conversations; and the ridiculous motion pictures, pertaining to the extraction of teeth might be compared to this historical incident. An execution, we all know, is a fatal procedure and hardly an incident to be written or talked about in a humorous vein. Any general surgeon or anyone practicing exodontia and oral surgery will frankly admit that the incising of living tissue is a serious matter. The surgical invasion of the osseous, blood, and lymph structures is something more than a mechanical procedure and requires more than a mechanic's knowledge.

I have heard dentists express the wish that, through the power of fate, they might at some time have the author or creator of a comic dental story or picture as their patient. "How he would suffer for his



"Before adjusting his neck for the blow of the executioner's axe, Sir Walter Raleigh, running his finger over its keen blade, remarked that it was a sure cure for all diseases."

insults!" they say. Generally, the inspiration for the writer's "revenge" came from the dentists themselves. It can't always be the patients' fault that an extraction was a horrible experience, as they, all too often, say it was.

IMPERTURBABILITY

In one of his immortal orations Sir William Osler said: "In the physician no quality takes the place of imperturbability. Imperturbability means coolness and presence of mind under all circumstances, calmness amid storm, clearness of judgment in moments of grave peril, immobility and impassiveness. It is the quality which is most appreciated by the laity, though often misunderstood by them; and the physician, who has the misfortune to be without it, who betrays indecision and worry, and who shows that he is flustered and flurried in ordinary emergencies rapidly loses the confidence of his patients.

"Even under the most serious circumstances, the physician or surgeon who allows 'his outward action to demonstrate the native act and figure of his heart in complement extern'; who shows in his face the slightest alteration expressive of anxiety or fear, has not his medullary centers under the highest control and is liable to disaster at any moment. An inscrutable face may prove a fortune. Cultivate imperturbability .... without hardening

the human heart by which we live."

The only comments necessary on Osler's words are: that the reader substitute the word dentist for physician, re-read the theme slowly and carefully eight or ten times, and he will know the first and most important quality of an exodontist. Too many of us, not only are, but look as worried as the patient while preparing for an extraction. Nothing could be more important than a course in anesthesia, exodontia, and *dramatics*, for future dentists. The first lesson should be the story of the man looking at the thundering beauty of Niagara Falls and, turning to a friend, casually remarking: "Damp isn't it?"

Those who do not have imperturbability should either make a conscientious effort to acquire it or refer their extraction problems to some other practitioner. Without it, all other valuable knowledge and skill is powerless to accomplish successful exodontia.

ANESTHESIA

Only yesterday, we heard the old, old story again.

Said the lady: "Doctor—— jabbed a large needle clear to the hilt into my tender gum, and then squirted all the freezing stuff in just as fast as he could. I felt dizzy and sick and fell out of the chair. Then the bold brute jerked me to my feet and slapped my face, (he thought I was unconscious) and told my dentist, who brought me to him, to pay no attention to my condition—that I was just a bit hysterical."

The proposed congressional bill to prohibit the manufacture and sale of firearms should be amended to prevent the manufacturers of dental needles from making, for use, any needle larger than twenty-seven gauge. Some clever, mechanically-minded inventor should then devise a governor to be adjusted to the fingers of the dentist making the injection to prevent the quick firing action we see and hear of too often. If any one wishes to take issue with my proposed use of such a small needle, let him do a little experimenting first. He should stick himself with a spike nail and then a sharp carpet tack. I would like a complete case report regarding the action of both. There may be some objections to slow injections and anesthetizing the tissues in advance of the path punctured by the needle, but I'll lay ten to one it is much less painful. In using the twenty-seven gauge needle, *unless the operator is particularly well-versed and skilled in the intricate tedious technique of removing broken needles he had better forget speed.* I will not insult your intelligence by telling you where to inject the anesthetic or how much to use. If you, by your experience and study, have not thoroughly understood that, this is another excellent place to stop. Gas anesthesia will not be discussed.

Doctor Seth W. Shields, Sr., my grandfather, would be very much pleased to learn, at the ripe age of 83, that his first lesson in extraction is still practiced to some extent. He was taught that, once the forceps were in their proper position, he should never remove them without the tooth in question or a portion thereof. If he did, no power on earth, he was told, could convince the patient that he should try once more; and then the fee would, not only be "unforthcoming," but the preoperative glass or two of whiskey would also be a total loss.

Why should we be conceited enough to think that our anesthesia is always profound? I get just a bit elated frequently and assure myself that, if the operation was painless, it was on account of my skill; if not, the patient was just another damned neurotic. A patient's complaint of pain at the start of an extraction should receive more than disinterested comments. After all, none of us like to be called liars, even by inference, no matter how beautiful the English or soothing the words. I have a friend who was diagnosed a neurotic by some mighty fine physicians and the diagnosis "stuck" for four miserable years until a surgeon removed a chronically infected, gangrenous appendix. His recovery from the "neurosis" was most spectacular following his operation. *Don't be too certain of your ability to diagnose mental and nervous diseases correctly.* Neuro-psychiatry is a highly specialized branch of medicine.

TOOTH EXTRACTION

To explain thoroughly the technique of tooth removal would require a shelf of books and articles that would dwarf the size of Doctor Eliot's five feet of volumes. I will leave it up to the individual dentist to determine the amount of reading he should do on exodontia; but, in my opinion, no finer admonition has been given than that of Osler: "To see patients without reading books is like sailing an uncharted sea, but to read books without seeing patients is like not going to sea at all." Try to strike a happy medium, follow it, and you won't be disappointed.

Doctor Adolf Berger says, "That the man who does not break teeth is the man who does not extract teeth." Don't be disappointed if one fractures during the process of its removal, but don't, whatever happens, look frightened.

Confusing indeed, is the literature from which we learn the different methods of the so-called surgical removal of teeth. We are told: (1) That impacted teeth should be split; (2) that impacted teeth should have the crown removed with the bur and the roots elevated; (3) the surgical bur should be used to remove interfering bone; (4) the alveotome should be used to remove bone; (5) the hand pressure ossiosector

should be used to remove bone; (6) the mallet and chisel should be used to remove bone; (7) the elevators should be used to remove bone; (8) the automatic chisel should be used to remove bone; (9) no bone should be removed.

The advocate of each technique is successful, respected, and firmly convinced that his method is correct. Don't make the mistake of accepting any one method until you have tried them all. They are all recognized and have been proved efficient, on many occasions.

POSTOPERATIVE CARE

Postoperative care is the fourth major portion of mouth surgery. It is also the one most neglected. There is no more golden opportunity in dentistry to please a patient than to provide for him an uneventful postoperative recovery. It is both possible and impossible but worthy of the effort. Again, I refer you to the textbooks and professional articles for your therapy. What I use may not produce results for you, so I can't turn down a chance like this to "pass the buck." Relief from pain, reduction of swelling, and localization of infection, should they occur, are the responsibility of the attending dentist. Whether it be done by local or general medication, a combination of the two, or faith healing makes no difference. Use the methods you now practice, if they give the desired results. Keep in mind the importance of mental therapy. Patients who do not have trouble deserve at least one postoperative appointment to assure them of the excellent condition of the operative site. Is it little wonder that the public does not have what we consider the proper respect for our art when we nonchalantly dismiss patients without impressing them with the importance of a routine postoperative care? I actually think some patients are more "dental-minded" than some dentists.

Exodontia, thanks to the many untiring, unselfish workers in its ranks, is rapidly taking the place it deserves in surgery. Just so long as the dentist shows a lack of confidence in himself, brutally administers his anesthetic, unscientifically and unsurgically removes teeth, and carelessly neglects postoperative care, certain persons will continue to say when informed of your professional degree, "Oh! You're just a dentist."

Hume-Mansur Building
Indianapolis, Indiana

BACK NUMBERS WANTED

Dr. Harry Reich, of 2021 Grand Concourse, New York City, would like to secure copies of ORAL HYGIENE from 1916 through 1927. Doctor Reich will be glad to hear from anyone able to supply him with these numbers of the magazine.

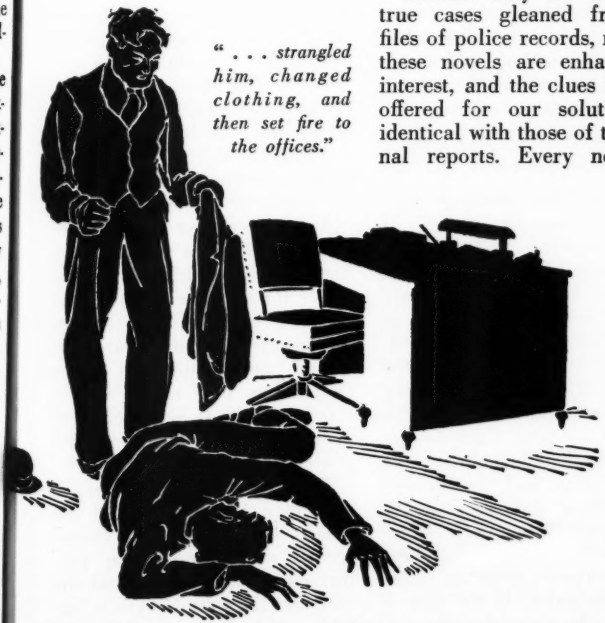
How Dentistry Can Aid in
CRIME DETECTION

Identification by Means of Dental Restorations

By J. EDWIN ARMSTRONG, D.D.S.

OUR love for adventure is an inherent weakness, which, if suppressed by environment, manifests itself in mental deeds of action. We long for the realities, but, fortunately or unfortunately, few of us ever reach beyond the limits of fiction. To many of us, the perusing of a good detective novel satisfies that craving for the unusual, and we content ourselves with capturing the fictional criminal mentally or solving the storybook murder to our own satisfaction.

Because they are based on true cases gleaned from the files of police records, many of these novels are enhanced in interest, and the clues that are offered for our solution are identical with those of the orignal reports. Every now and



". . . strangled him, changed clothing, and then set fire to the offices."

then, such a story activates our impulses by presenting a clue built around a strictly dental problem. In other words, we are intrigued into extreme interest by the professional side of the solution.

Today, criminal investigation is assisted by an elaborate array of sciences. Chemistry, medicine, dentistry, metallurgy, and many others, are employed in solving crime and rendering identification possible. How important all these sciences are can readily be determined by examining the records of the Scotland Yard officials. Their success is based on checking every angle of a clue and filing the complete data for reference. Nothing is overlooked, because impertinent factors frequently furnish the solutions to unsolved crimes.

DENTISTRY AIDS IN CRIME DETECTION

The part that dentistry may play in crime detection is a very important and exacting one. It may be the only branch of science to solve the mystery of an unidentified body and, as we all know, identifying a murder victim usually furnishes the most important clue in tracking down the murderer. In the course of the year, many bodies are found throughout the United States, and the percentage of those definitely identified is small. When such bodies have lain for weeks and months little remains to assist the criminal investigator. If the case is proved to be a murder, the victim has usually been stripped of every possible clue. If it is a suicide, there is also a big possibility that the person has eliminated any means of identification before he eliminated himself.

These are the cases in which dentistry can play an important rôle, provided that the authorities do not fail to complete their investigation. No matter how badly decomposed or mutilated the body is—*the teeth usually remain as tell-tale evidence.* It is then an accurate charting of the teeth and other dental abnormalities must be made. All restorations, bridges, missing teeth, malposed teeth, structural deformations, or other peculiarities should be accurately tabulated. Sometimes such a chart is augmented by photographs and roentgenograms. Copies of this record can be sent to all dentists in the community surrounding the locale of the crime.

In many of our larger cities this has become a routine practice, and the work is handled either through the coroner's or sheriff's office. The possibilities of identification are extremely good, especially if the victim has had recent dental service, or if he is someone of prominence and has been reported missing.

The failure in many cases is attributed to the laxity of the dentist in keeping an accurate record of the operation performed on the patient and the fact that no definite system has been worked out for dissemi-

nating information throughout the country. If every practitioner kept an accurate record of his patient, not only of the operation he has completed, but of previously performed services, it would assist materially in solving many cases.

TYPICAL CASES CITED

How important this part of criminal identification can become may be readily understood by citing some interesting cases recorded in recent years. A typical one reports that a fire destroyed the offices of a prominent man in one of our large cities. A search of the ruins revealed the body of a man. It was assumed by authorities that the victim was the tenant of the offices. As the body was sufficiently burned to render recognition impossible, and his family thought the man was there at the time of the fire, the case was closed and a jury brought in a verdict of accidental death.

Here was a pertinent factor! During the inquest, relatives of the man identified a set of dentures removed from the body as being those of the victim. This bit of evidence seemed to satisfy the jury as to the identity. However, there was a $100,000 indemnity to be paid to the family, and the insurance company was not satisfied. They investigated further and finally revealed an interesting story of fraud. The body found was not that of the alleged person, and the insurance company proved it by finding a dentist who had recently made plates for the alleged victim. By accident he had kept some models, and these models were entirely different from the dentures found. The insurance company immediately broadcast a description of their policy holder, offering a large reward for his apprehension. He was finally found, confessed having lured the victim into his office, strangled him, changed clothing, and then set fire to the offices. His idea for getting $100,000 for his family was a good one—but he made one error. If he had left his own dentures in place of the other man's the story would have been in his favor.

Just recently, in a desolate area of San Diego County the body of a man was found. From all appearances he had been murdered about six months before. Nothing of importance was discovered, with the exception of pieces of clothing, a pair of shoes, and bits of the hair and beard. From these, authorities reconstructed a general description, giving, as usual, height, weight, color of hair, age, and other facts. The description was broadcast immediately in the hope that the authorities would be notified of such a missing person. This proved effective—and a man reported that he felt, without doubt, the body was that of his cousin, who had come here to buy some land, then had disappeared without leaving any word as to his destination. His description tallied closely with the description of the body—

even to his remembering that his cousin rolled his own cigarettes out of brown paper. Incidentally, brown cigarette papers were found in one of the pockets of the clothing. By ascertaining the victim's name and residence, it was easy to have the files of the dentists in that community checked. A wire was dispatched asking for details of any dental operations performed on the man. The following day the necessary information was received from one of the dentists and comparison made with the teeth and jaws of the body. There was no resemblance! The murdered victim still remains unidentified, although hundreds of charts of the teeth have been mailed throughout this section of the state. In the May issue of ORAL HYGIENE* a copy of this chart was published. It is my hope that some dentist will be able to lend assistance in making the identification.

These stories illustrate how important dentistry may become at times in crime detection. In the case of the second story it was practically as important to prove the body was not that of a certain person as to prove that it was. There are many cases on record where positive proof has been established by just a small, insignificant piece of dental work. I remember one such case in which the set of teeth encountered was perfect except for a missing lower first bicuspid. There was no evidence of extraction, and the second bicuspid was in approximation with the cuspid. Although identification had been practically established, still there was no definite proof. Finally, a dentist volunteered some information. He believed he had cleaned the teeth of this victim and had made roentgenograms of his lower bicuspid area. He reported finding an impacted tooth. An examination with roentgen rays was immediately made of the victim's jaw, and the impacted tooth discovered. Fortunately, the observant practitioner had retained the roentgenogram and, on comparison, the structural characteristics were found to be identical. Proof had been established beyond a reasonable doubt, and those roentgenograms were as valuable as comparative finger prints.

These stories are typical of hundreds on record, and if space permitted many equally convincing ones could be told. It is only by such concrete examples that one can emphasize a thought or build up a theoretical problem.

After reading this far haven't you asked yourself the question, "How Can Dentistry Be Used to Greater Advantage in Crime Detection?" That is the problem uppermost in my mind while writing this article. So far, in comparison to the other sciences, we have fallen far behind in our service to law enforcing agencies. It is true that

*Seek to Identify Man Through Dental Work, ORAL HYGIENE 24:714 (May) 1934.

there are isolated examples of members of the profession who have interested themselves in crime detection to such an extent as to make themselves indispensable. Starting out with it as a sort of a hobby, they have become so engrossed in the work as to achieve results that merit marked attention. Some have adapted themselves to such a degree as to rank as experts in fingerprinting, photography, and makers of face casts—all while still practicing their profession. From casual observation it appears there is a real opportunity for the dentist to delve into the field of criminology. The medical man has ventured into it wholeheartedly, and his services have been accepted and found advantageous. We, as a profession, are closely associated and possess certain knowledge of the dental field, of dental plasters, plastics, and alloys which are frequently important in criminal detection. Surely the law enforcement body in a community of any size has need of such knowledge on many occasions. Dentists who are interested in such activities can find a ready field, but they must be willing to do a little work and not expect too much compensation. I believe that, in the course of time, such a group of men would be an important cog in the machinery of criminal departments. Many new ideas on crime detection would be evolved, and the interchange of these ideas would help to simplify the problems of our complex law enforcement bureaus. If a large enough group were active, an informal national organization could be formed.

In conclusion, there is another important thought which must be reconsidered. Earlier in this article the apparent laxity of many dentists in keeping accurate records of work performed on their patients was mentioned, as well as the lack of a suitable medium for disseminating dental descriptions of unidentified persons. If every dentist did keep accurate records and, if such a dental journal as ORAL HYGIENE maintained a department for identification, it is easy to see the possibilities of establishing the identity of some of the many hundreds of bodies found each year. However, this means cooperation and a display of enthusiasm on the part of a large number of men.

To be effective in this work, a periodical must be national in scope and must reach every dentist. The question is—"Are There Enough in the Profession Interested in Crime Detection to Warrant the Establishment of Such a Department in a National Dental Journal?" Personally, I feel that such a move would be followed with interest and, in time, an informal organization of those dentists who work with law enforcement bodies could be formed.

First National Bank Building
San Diego, California

The DENTIST'S EYES

By OLIVE GRACE HENDERSON
AND
HUGH GRANT ROWELL, M.D.

GLASSES, in any language you choose to express it, are a sign of abnormal eyes. They may be becoming glasses. They may make us positively beautiful or distinguished, and they may enable us to see as we never saw before. But no one has yet made the claim that a normal eye without glasses would not be better.

Eyes, like human beings or animals, can be happy or they can be miserable or perhaps merely a trifle under the weather. And, like many human beings, the eyes are not content to confine their troubles to themselves. While bad eyes will probably never cause bad teeth, they can give us actual (not figurative) pains in the neck, spoil our golf, our tempers, and even give the Gnadige Frau ample grounds for divorce.

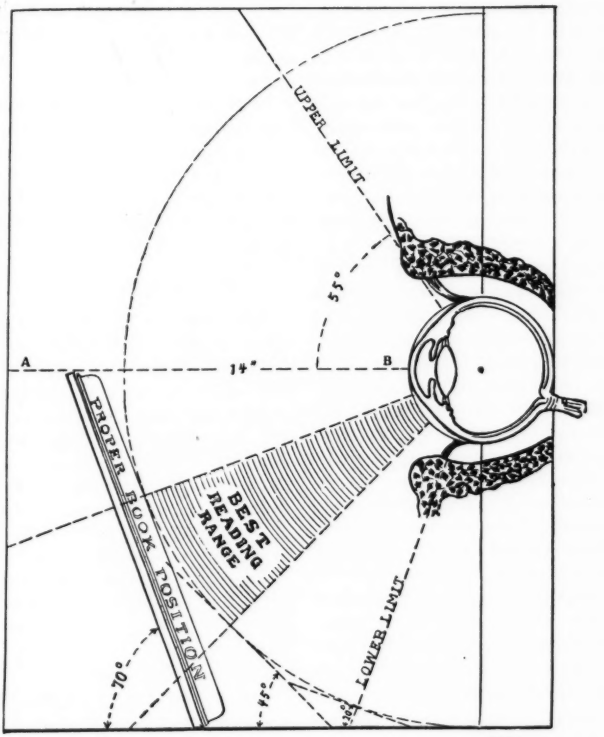
If then, we wish *good eyes for life* for ourselves and families (and, if generous and social-minded, for the rest of the world), it behooves us to consider how eyes may get into trouble, and turn ourselves into missionaries and evangelists to save them from themselves, from the gutters of eye iniquity and the subsequent "paying the Piper", though not from destruction (which is to be interpreted that, while impaired vision is common, blindness is rare).

PRINCIPLES OF PROTECTION

There are certain principles of eye protection which apply anywhere, whether in the halls of learning, the clinics, the private office, the home, or other spots. In terms of whatever eye troubles are preventable, eye protection is the real answer. And, if certain eye conditions, such as some cases of nearsight, are hereditary, good care of the eyes is certainly going to improve your chances of having less trouble with the legacy grandad left you.

Close work in bad light in bad position makes more trouble for eyes than anything else. Bad light is the kind of light we usually have. If you take one of these new light-meters (based on the photo-electric cell) and measure the illumination you get on the book or paper at home, or what your patients use when they study that *Literary Digest* with the straw vote on George Wash-

Illustrations (Figures 1, 2, 3, and 4) are reproduced from the book, GOOD EYES FOR LIFE by Olive Grace Henderson and Hugh Grant Rowell, M.D., through the courtesy of the publishers, the D. Appleton-Century Company, New York City.



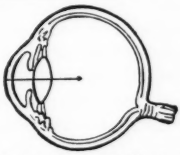


Fig. 1—READING POSITIONS AND THE EYE

Cut out the eye on the right and place it over the eye in the drawing. The line A-B represents the line of vision when the eye is looking forward. The line touches the retina at the point of most acute vision. In reading, the book should be held at a right angle to this line. But the movement of the eyeball or the head shifts the line of vision, so that an angle of 45 to 70 degrees is more practicable. Thus the eye may be turned downward within reasonable limits and the head may be bent slightly for more comfortable posture. The importance of proper angle, height, and distance becomes clear as the eye is turned to the various angles of vision.

ington's Presidential campaign, you will be astonished to find you are not providing more than five degrees or footcandles as compared with the ten to thirty (according to individual preference and comfort) which the good book of the illuminating engineers tells us is the light that should lead our eyes along happy pathways.

Light is specified, not only in terms of quantity, but also of quality direction. There is a thing called *glare,* as deadly as mother-in-law's banal stare and far more painful. It reveals itself in discomfort. It has all the sadistic qualities of eye-gouging in a wrestling match.

Direction means from above and behind. In writing we have the light on the opposite side from the working hand, to avoid shadow.

Dental operations offer peculiar eye problems, peculiar problems in lighting. Perhaps the best standard of determining the lighting is your own comfort. Find a strength of light you like, measure it, maintain it. And it has always seemed an exceedingly wise practice in dentistry to take a rest from gazing into a tooth's innards at regular and very frequent intervals. Work benches, everywhere in the office where eyes are used, ought to be lighted adequately, probably twenty to thirty footcandles or meter degrees being about right.

We went to a man who has long studied dental technique. We put to him the question, "Why do dentists rate so high in Luckiesch's eye defect groups?" Here is what he stated.

First of all, many dentists buy expensive equipment, planned to make their work easy—easy on eyes, easy on the rest of the body. But they fail to make the equipment work for them.

Position Of Light

The position of the light is often faulty, creating a hand shadow. With the ordinary fifty watt light, it is possible always, by manipulating light and the patient's head, to avoid hand shadow (a thing comparable to the writing shadow found in schools where lighting is incorrect). A simple shade protects the patient's eyes.

It costs no more and, probably less, to light your work accurately as compared with badly planned illumination.

Dentists often fail to use the levers of the chair to bring the work up in the scope of vision. This parallels our own advice to bring the work up to the eye, not the eye down to the work—easier on back and neck, avoiding the undesirable downward-looking position.

Manipulation of the light on the examining lamp makes it possible to avoid eye punishing glare from that source, a glare both unnecessary and harmful to the eye.

There is a further factor, claims our informant, the fatigue element. General fatigue has an indirect effect on the eye

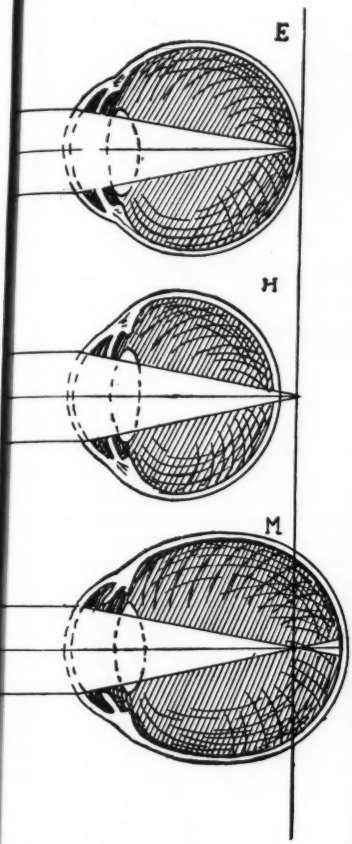


Fig. 2—THREE EYES

(E) The normal, or emmetropic eyeball. (H) The short eyeball of farsightedness, theoretically with the image behind the retina. (M) The long eyeball of nearsightedness, theoretically with the image in front of the retina. (After Kerr.)

through requiring longer use of the eye to accomplish the same objective. So it is a case of plan the work, manipulate the patient, not curl your back and neck into knots. Make the chair work, not your body. Follow the example of the operating surgeon who maintains position. Stools sometimes help, if balance can be maintained.

The downward-looking position for eyes was splendid to betoken the modesty of the mid-Victorian maiden but the custom was certainly not intended for the eye-worker. If there are any tendencies toward nearsightedness which some unkind forbear has passed on to us, then this eye position is even less desirable. As shown in our recent book[1] several reasons are advanced to explain why the eyeball may become elongated under such conditions, but the selection of the right theory is a matter best left to ophthalmologists to agree upon first.

Turning once more to reading, if you want to read happily, the proper position for the book is at an angle of between forty-five and seventy degrees with the floor line, between fourteen and eighteen inches from the eye (if your vision is normal) and high enough so that you can sit erect, the trick being to bring the book up to the eye, not the eye down to the book. The

[1]Henderson, O. G. and Rowell, H. G.: Good Eyes For Life, New York, D. Appleton-Century Company, 1933.

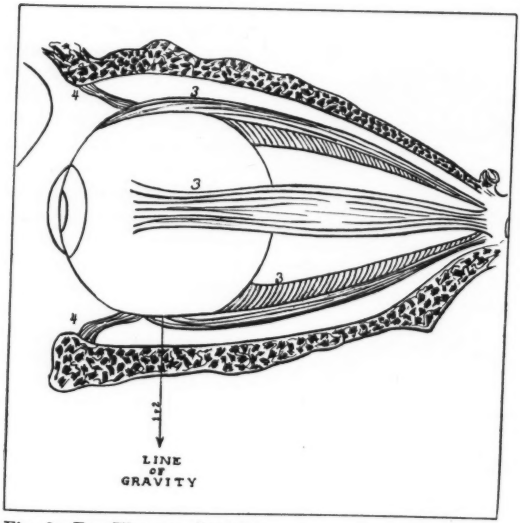


Fig. 3—EYE WORKING IN A POSITION OF REST. SHAPE NOT DISTORTED.

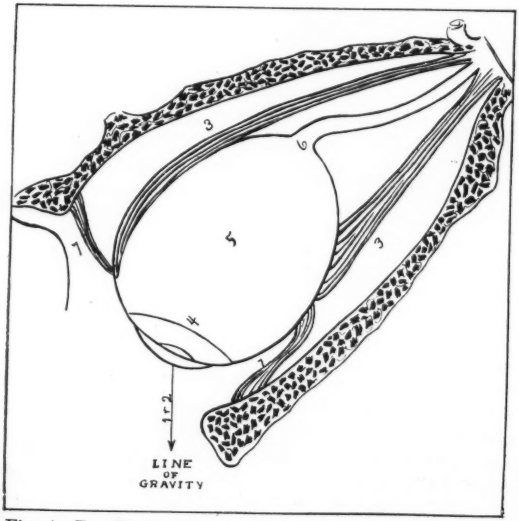


Fig. 4—EYE WORKING IN AN UFAVORABLE POSITION. SHAPE DISTORTED.

range of angles and distances is important because all of us have somewhat different preferences.

A school child's eyes, as he grows, can be given a chance to grow strong instead of weak, if he has a modern desk at home or school (as happens occasionally), so he can obtain the proper position through simple adjustments he makes for himself with his desk top. He can, as a matter of fact, build for himself a simple reading stand which does pretty well, too. And he finds, what the old-time monk knew, that you can write comfortably at such angles, heights, and distances and draw and paint as well.

A similar thing can be accomplished by using piles of books and some of the portable reading stands do the job fairly well in the home. We have to use mechanical means because our arms tire holding the books, and we are soon curling ourselves up in knots or resting books on our knees and hanging onto chair backs by the napes of our necks.

The proper working angle has, incidentally, the possibility of making poor light better or lessening the amount of light needed to get that ten to thirty footcandles on the work. The lightmeter has proved this.

Factories have been applying these principles to a considerable extent. On the other hand, studies of certain trades where the stooping position was used at work have revealed high percentages of nearsightedness.

The eye, we are beginning to realize, "has just begun to come indoors," as the great physicist, Matthew Luckiesch, put it. It was built for distant vision, for seeing comparatively large objects, for hunting, fishing, fighting. Its rest position during waking hours is that for distant vision. But when we begin to use it at distances of less than three or four feet, the closer we get to the work, the more the burden. Use it in bad light and bad positions and we are that much worse off. Use it efficiently and we get along rather nicely.

The eye is born farsighted normally. It is not till we are five, six, or seven years of age

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Fig. 3—(1) *Weight, 7 grams, and* (2) *gravity pull at line of gravity would tend to prevent the eyeball from elongating.* (3) *Equal pull on recti muscles, causing no additional pressure.* (4) *Superior and inferior oblique muscles, which rotate and focus the eye, are not working under tension.* (5) *Good posture promotes proper nourishment of the eye.*

Fig. 4—(1) *Weight, 7 grams.* (2) *Gravity pull.* (3) *Muscle pinching.* (4) *Blood congestion expands front of eye.* (5) *Internal pressure, 25 millimeters, will elongate the eye when expanded.* (6) *Optic nerve pull.* (7) *Superior and inferior oblique muscle pinching.*

Here are a few suggestions for studying the dental office:

Reception room.

1. How much light[2] does your patient get on the magazine reading surface?
2. Is the light from above and behind? Try this on your secretary's desk too.

Laboratory

1. How much light is on whatever work you or your assistant is doing?
2. Is the light on the work or in the worker's eye?

Operating Room

1. Is any light uncomfortably strong in your patient's eyes or does it shine in your face, for that matter?
2. Is the light on your instrument cabinet strong enough to enable you to distinguish and grasp instruments quickly and easily?
3. Is the light you use in examining or operating strong enough to reveal what you wish? Does it, at the same time, avoid reflecting back into your own eyes uncomfortably?
4. How often do you stop, look off in the distance, or close your eyes for a moment?
5. Is your work planned to conserve your eyes and to avoid fatigue in general?

The best standard is how tired eyes and back are after the day's work.

Home and elsewhere, as for reading.

1. Do you and your family observe the standards of lighting and position outlined earlier in this article?

that we attain the normally spherical eye ball and even then we have a tender, unstable organ of vision. Schools and homes have a tremendous responsibility for eyes which they have been meeting with difficulty, though the advent of the lightmeter as a simple means of measuring light and placing school seats, plus the newer type of angle-height-and distance desks make the future look more promising.

We have not learned how to read properly, or, for that mat-

[2]The modern electric light companies usually have a modern lightmeter available.

ter, to work with proper intervals of eye rest and techniques planned on an eye-saving basis.

If all the dentists (who happen to be the group under discussion at the moment) and their children, and their sisters and their cousins, and their aunts, who would fail to receive passing marks on this questionnaire were placed side by side they would reach from the Statue of Liberty to the Statute of Limitations. And the money they could save on aspirin by not having avoidable headaches would probably pay for their postage stamps.

525 West 120th Street
New York City

But don't think you are alone. Abusing eyes is a more popular sport than football or Senegambian Golf, which accounts for some degree, at least, of the thirty-odd percent of New York subway patrons of all ages our observers found wearing glasses or the forty-odd percent of physical education majors (a physically superior group) we found in one large college. The only question is, what group is going to be the first to realize (and act upon the idea) that it is no small asset to have and to keep *good eyes for life?*

Dental Meeting Dates

Northeastern Dental Society, Swampscott, Massachusetts, June 13-15.

Georgia Dental Association, 66th annual meeting, Piedmont Hotel, Atlanta, June 11-13.

Colorado State Dental Association, annual meeting, Cosmopolitan Hotel, Denver, Colorado, June 18-20.

Minnesota State Board of Dental Examiners, regular meeting, College of Dentistry, University of Minnesota, June 22-28.

New Mexico State Board of Examiners, regular meeting, Albuquerque, New Mexico, June 27-29.

Southern Society of Orthodontists, 13th annual meeting, The Homestead, Hot Springs, Virginia, June 16-18.

The American Full Denture Society, sixth annual meeting, Spanish Room, Hotel Lowry, St. Paul, Minnesota, August 4-5.

American Dental Hygienists Association, 11th annual meeting, St. Paul, Minnesota, August 6-10. Headquarters will be the St. Francis Hotel.

American Dental Association, 76th annual meeting, St. Paul, Minnesota, August 6-10.

W. Linford Smith
Founder

ORAL HYGIENE

EDWARD J. RYAN, B.S., D.D.S.
Editor

Editorial Office: 708 Church Street, Evanston, Illinois

Give me the liberty to know, to utter, and to argue freely according to my conscience, above all liberties. — *John Milton*

AFTER THE DENTAL HEALTH SURVEY, WHAT?

DURING the administration of President G. Walter Dittmar of the American Dental Association there was appointed a Committee on Dental Health Survey "to ascertain the dental health needs of the public."[1] Twenty-nine members of the A.D.A. comprised this committee. The United States Public Health Service "agreed to authorize experienced dental officers of the USPHS to make the survey."[1] Members of state and local dental societies have done most of the actual work in conducting the examinations. "All of the necessary forms for making this survey will be furnished by the Public Health Service. . . ."[2] From this we may presume that the records will be the joint property of the federal government and the A.D.A. This, therefore, represents a cooperative project between a professional organization and an important *federal* governmental department. This precedent is important and may be of far-reaching significance.

With this factual background, an interpretation of the activity is permissible while awaiting the report of this survey. Here and there a few dentists have expressed a dissenting opinion and an apprehension that the final report of this survey may be a blow to private practice rather than

[1] Dittmar, G. W.: President's Address, J. A. D. A. 20:1943 (November) 1933.

a boon. None has questioned the motives of the dental leaders who initiated the survey; they acted in the best faith. And the solicitation by the A. D. A. and agreement of the USPHS to cooperate have generally been considered a triumph for organized dentistry.

In times of rapid social changes it is well to consider everything that is new and experimental from the standpoint of patterns from which permanent structures may be built. An inquiring attitude in the matter of this survey suggests a new pattern: an interest by the federal government in the dental health of citizens. From this innocent blueprint a structure could be erected that might overshadow private dental practice. We mean, to be specific and direct, widespread dental activities by the federal government through the agencies of the USPHS.

We scarcely need the figures and tabulations from the survey of dental needs to anticipate what the findings will be. We will be told nothing new. The story of rampant, untreated dental disease will be repeated, with this difference: that now conditions will probably be shown to be *worse* than in previous local surveys. The economic plight of thousands of American families during the past four or five years will be reflected in the mouths of the children of these families. Likewise the breakdown of public school dental departments, a part of the chaos in the public educational system (unpaid teachers, closed schools, curtailed activities, tax strikes—only a part of this sorry picture), will show in the results of this survey.

Some of us may take the position that a report recording dental horrors and an appalling incidence of dental disease will awaken the public to these grave conditions; that from this awakening private practice will profit. Those of us who reason thus will argue that the cooperation of the USPHS will give the report an official stamp of approval that will be accepted more readily than the results of a survey made by the A.D.A. alone. Unquestionably the activity of the USPHS in the study will carry considerable authority with social workers, public health administrations, the Funds and Foundations, legislators, and the public. **In this very fact is the danger!**

After we have reported to the American people the dire conditions that exist in the mouths of their children, how these conditions may affect their future health, why they should be corrected—what is our next step? After the diagnosis, what is the therapy?

If dental disease is so prevalent and so serious in its nature as to command the attention of the Public Health Service, it may be, social scientists may argue, a problem too large to be handled by the present distributive system of private practice. Economists may pick up the argument and point out that the dental condition is, in part, a result of the unequal distribution of wealth and that the "new poor," are the chief sufferers. If such is the case the suggestion of health insurance looms large as a corrective. What capital legislators who veer toward the Left might make of the situation is apparent.

"When the survey is completed, the information obtained will be made available as soon as possible, and it is hoped that the American Dental Association will be able to recommend some definite policy for dental health education and dental care."[2] What *concrete* and *practical policy* will the dental profession be prepared to offer, or must those outside the profession be compelled to force the issue? After the survey—what?

[2]Editorial, J. A. D. A. 20:2068 (November) 1933.

HARRY J. BOSWORTH DIES IN CHICAGO

It is with a feeling of genuine regret that we record the death of Harry J. Bosworth in Chicago on April 17. Known throughout the profession as a generous and loyal friend, his passing brought a sense of personal and professional loss to hundreds. Ever since he became associated with the dental supply business in 1890, Harry Bosworth had given unsparingly of his time and experience to aid in the development of the dental profession. Through his constructive efforts he made a definite and lasting impression. To those who knew him intimately as a friend and to the members of his family, ORAL HYGIENE extends sincere sympathy.

DENTAL RELIEF *for the* Profession

By M. GILBERT, D.D.S.

THERE is much discussion about giving free dental service to the poor. It seems to me, though, that in our anxiety to take care of the poor people's teeth some of our leaders are overlooking the fact that the dentists and their families also have teeth that are crying for food.

I am a practicing dentist and, therefore, familiar with the distressed conditions prevailing in our profession. To be brief, one-third of the dentists are not earning enough to cover their minimum expenses, with the result that they are not in a position to meet their rent and supply bills.

Moreover, we all have outstanding accounts which are uncollectible. Quite a number of the dentists have informed their patients that they have wiped off their debts. The work that we currently do is at minimum fees but, even at that, we find it extremely difficult to collect.

Our profession, as is generally known, does a great deal of charitable work to relieve pain and suffering free of charge for the indigent. The majority of dentists are on duty from 9:00 a.m. to 9:00 p.m. daily and half-days on Sunday.

There are approximately 60,000 dentists in the United States and, roughly speaking, one-third are managing to get along fairly well, one-third find it very hard to meet their obligations, and finally 20,000 are literally on the verge of complete breakdown or, you may say, starvation[1].

In New York City alone, it is conservatively estimated, 1000 dentists were forced out of their offices, being unable to pay their rent. The newspapers even reported several instances of suicides while the furniture was being carted out to the streets.

My plan proposes that the various dental societies should use their influence with the President to see that the United States Government should advance through a dental commission, appointed by the President, to the 20,000 dentists in distress, $1000 each to be paid off in the following manner:

The millions of unemployed who have in the past few years entirely neglected the care of their teeth require immediate dental attention; and they

[1]Editor's Note: There are no figures to substantiate this statement, which is an opinion and, therefore, should not be considered as a statistical report.

should have this dental work done. The dental commission could establish a reasonable standard of fees for this special work and provide for each person to get from three to twenty dollars worth of work done.

Thus, with the $20,000,000 fund, between two and four million persons obtain this greatly needed relief work. The charitable institutions together with the dental supervisors could be utilized to pass on persons needing such work, as well as the extent of the work. They would refer the patient with a note to the dentist who would, in this way, pay off the government's advance of $1000 at the rate of approximately $80 a month.

Now I want to enumerate the benefits that will accrue from the adoption of this plan.

First: The $1000 will help each dentist to meet his obligations and also to help to carry him until such time as things improve. This direct benefit will help some 100,000 persons connected with the profession and industry, such as, dentists, assistants, employees of supply houses and laboratories, salesmen, and clerks.

Second: It will help that portion of the public which most urgently needs help and this important social service will bolster the public morale, as well as physical health.

To illustrate further the existing conditions: some of our dental societies are trying to take up a collection to help turn on gas and electricity which were shut off in some offices. But, unfortunately, there are not many dentists who are themselves in a position to contribute to such a fund.

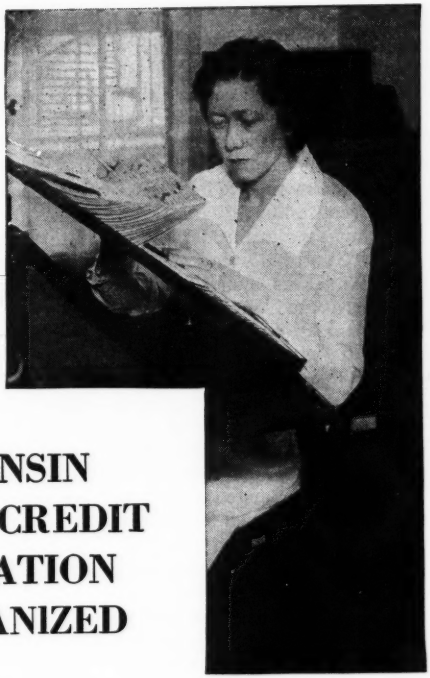
The plan should especially commend itself because it does not involve clinics but, in accordance with the entire underlying philosophy of the NRA program, helps the profession to help itself.

Dental care, particularly where it has been neglected for a long time, ranks as an essential service, with food and shelter.

To further explain the importance of dentistry for the benefit of the layman who may read this article, I want to point out that in a majority of cases where people get sick they use home remedies and Nature helps them to get better. In the case of dentistry where home remedies instead of a dentist's services are used, this usually ends in the death of the pulp with an abscess forming, the pus being absorbed, thus causing systemic disease.

To assist the youth of the nation to healthy and vigorous maturity and to assist the dentists who are greatly needed for this work, I hope that dental societies will do their best in helping to bring about the early adoption of this plan.

432 Seventh Avenue
New York City



By
EDWIN
J.
BLASS, D.D.S.

WISCONSIN DENTAL CREDIT ASSOCIATION IS ORGANIZED

THE sum of money represented in all unpaid dental services rendered the American public during the past ten years, divided equally, would enable every dentist to pay every delinquent laboratory and supply house account. It would wipe out regrets of those who invested in stocks and bonds, now worthless, and would leave a balance sufficient to distribute to every member of the American Dental Association enough money to take care of all immediate needs.

Frozen assets have been responsible for the closing of thousands of banks during the past few years, and if immediate steps are not taken to conserve the dentist's assets, frozen to a degree of death, a similar fate will await us. The financial condition of many dentists right now borders on bankruptcy, but salvation is imminent for those who heed the warning and give credit only as the banker gives it.

ORIGINATE CREDIT PLAN

The dentists of Portage, Wisconsin, more than two years ago, united on a plan to protect themselves against the virus of

abused credit. After a survey was carefully made of ledger accounts, it was discovered that many persons were owing several offices at the same time. The dentists reported that no response was received to statements sent to the very ones who were buying gasoline for pleasure trips and indulging in other luxuries. This condition demanded correction. Therefore, an organization was completed under the title of the Portage Dental Credit Association. A lay secretary was secured and to him every dentist in the city sent a complete list of all delinquents of ninety days or more. The list was arranged alphabetically and classified according to degree of difficulty in collecting bills. Those who had previously paid but, for some reason, had not paid for ninety days were marked, G; those who were habitually slow in paying, S; and those to whom statements were repeatedly sent and possibly given to a lawyer to force collection were labeled, NG. A combined list from all the dentists was made into one list which was sent to every dentist in the organization for his and his assistant's sole use.

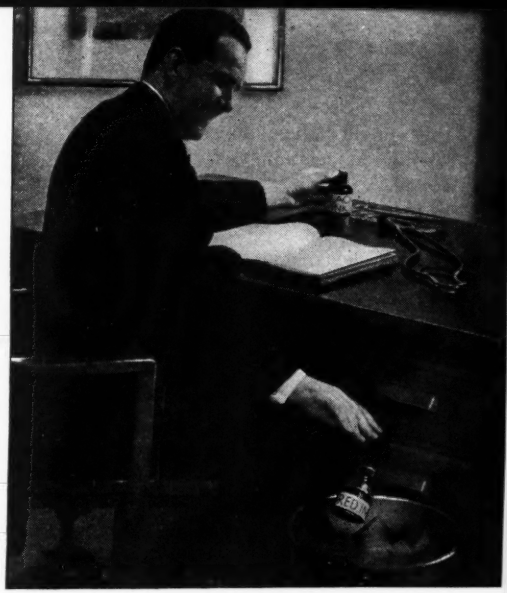
The secret of the great success of this credit association was that much publicity was given the organization. A blazing front page write-up of the initial venture appeared in the daily and weekly newspapers and every one in the vicinity became conscious of the fact that the dentists of Portage expected and demanded payment for all services henceforth. Announcement was also made that any one whose name appeared on the list would be denied further service, unless his account was cleared or cash paid in advance before the new work was begun.

Meetings of the members of the credit association are held every three months and, at that time, the list is corrected.

After operating the plan for about a year, we realized that our aims were thwarted to some extent by those delinquents who would drive to a nearby town for dental service and "stick" the other fellow. This abuse was corrected by incorporating the neighboring dentists in the organization. Today, we have practically every dentist within a range of thirty-five miles of Portage cooperating with us, and we are now operating under the title of the Central Wisconsin Dental Credit Association.

News of the phenomenal success of our efforts has spread to all corners of the state. Recently, I talked on our plan before the members of the Jefferson County Dental Society, who now have organized a similar plan and are reaping the reward of their efforts.

Our methods are simple and business-like and are operated with comparatively no expense to the dentist. Patients do not want their names on what they call the "dead-beat" list. Where before they had no qualms about owing a dentist, now they make an effort to pay.



"Judging from inquiries received relative to our organization from members of the medical profession, the day is near at hand when they too will hold the winning hand against these same unfair or dishonest persons who seek service, but are unmindful of the proper remuneration."

Every city, town, and village should have a credit association such as ours. This plan in some form has been adopted by chambers of commerce and organizations of business and professional men in various cities with some degree of success. It has been found, however, that certain persons will pay their grocery and meat bills but overlook obligations to the professions. For this reason, an organization, such as ours, functions far more satisfactorily, and experience has taught us that dentists should organize their own group to solve this credit problem.

Seek State-wide Organization

We are anticipating a time when the entire state of Wisconsin will operate as one organization; and, when this is realized, the profession of dentistry will be conducted on a business-like basis. Undoubtedly, better dentistry will result, and laboratories and supply houses will be able to take care of our needs at a lower price if we are paid for all services rendered and are thereby enabled to pay them.

Dentists cannot pay their bills when patients do not pay theirs, and the dentists who have had a taste of what the Central Wisconsin Dental Credit Association has accomplished are no longer adding more liabilities to their overburdened shoulders. The leeches and careless ones who are present in every community had their death knell sounded on any fur-

ther credit when the Dental Credit Association was perfected.

Those persons who have no hesitancy, whatsoever, about incurring debts, and who make no effort to pay their obligations, if it means restricting their own pleasures, now find this one field closed to their inroads.

Physicians have experienced the same or a worse abuse of credit than we have. Judging from inquiries received relative to our organization from members of the medical profession, the day is near when they too will hold the winning hand against these same unfair or dishonest persons who seek service, but are unmindful of the proper remuneration.

The professions have every right to expect and could demand the same method of business procedure that is exemplified by the chain stores. Cash for every transaction over the counters enables them to sell more cheaply and render better service. The ancient but honorable code of ethics adopted by members of the professions calls for service to all who ask for it. Even at a great personal sacrifice we have reponded to calls of distress, regardless of the time involved or prospects of pay.

A casual glance in the ledger of any dental office, however, would at once convince the investigator that this method should have been adopted two years ago to curb the gross abuse of the dentist's willingness to accommodate his patients by allowing them convenient time or monthly payments by which they can liquidate their dental accounts.

The members of the Central Wisconsin Dental Credit Association are proud of their organization and gratified beyond expectations at the results obtained. The problem we had must have been that of others also. Hence, the remedy that cured our trouble will be effective wherever it is applied. The New Deal will manifest itself in our profession much more rapidly if in every community dentists, not now organized, will take immediate steps to stop charging accounts to persons who either deliberately or, for a cause not within their control, fail to reimburse the dentist for services rendered.

Portage, Wisconsin

The Philadelphia District Dental Hygienists Association wishes to announce the opening of a registry for Dental Hygienists. Any dentist desirous of securing the services of a Dental Hygienist please address all communications to Miss Helen Temple, 128 N. 50th Street, Philadelphia, Pa.

Ask ORAL HYGIENE

Please communicate directly with the Department Editors, V. CLYDE SMEDLEY, D.D.S., and GEORGE R. WARNER, M.D., D.D.S., 1206 Republic Building, Denver, Colorado. Please enclose postage. Questions and material of interest will be published.

IMPROVING CONDITION OF SALIVA

Q.—I have a patient whose saliva is so thick and sticky that it is almost impossible to do work in his mouth. Is there anything that can be given in such a case to thin the saliva and check the flow to some extent?—E.J.B., D.D.S., Minnesota

A.—Ropy saliva can be corrected through the diet. Have the patient eliminate all starch and sugar for a time. Advise him to partake freely of nonstarchy vegetables and fruits, particularly citrus. After the saliva has become normal in consistency, he can again take some carbohydrate food regulating the proportion so as to hold the saliva at the correct consistency. This dietary regulation should tend to check decay and improve elimination and otherwise be of benefit to his general health.

I know of nothing that will act as an immediate solvent to relieve the mouth of ropy saliva during the period of one sitting. I wish I did. If some of our readers can tell us of such an agent, it will be greatly appreciated.—V. C. SMEDLEY

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ABSCESS IN LATERAL REGION

Q.—A patient who has been wearing a full upper denture for many years came to my office because of a large abscess in the upper lateral region. The abscess extended to and almost surrounded a small undeveloped cuspid that was easily removed. This was less than a week ago and the cavity, which is as large as a hickory nut, still discharges a little.

How long should it take this cavity to fill in and how long before a denture should be worn? If the discharge does not soon stop, do you advise a thorough curetting?—H.H., D.D.S., Ohio

A.—If the cavity was lined by a cystic sac or, if there was a necrotic bone present, they should have been removed at the time the cuspid was removed. As it is I would not be in any hurry to open the area

again unless drainage continues for more than two or three weeks.

A denture could be worn any time after the drainage ceases.

It may take from three to six months for so large an area to fill in with new bone. Make a roentgenogram of it every two or three months and, if it doesn't seem to show progress toward filling in properly, it should then be opened up and cleaned out thoroughly.—V. C. SMEDLEY

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BURNING SENSATION

Q.—About two and one-half months ago I made a full upper and lower vulcanite denture for a patient of mine, a woman. Now she describes a drawing and a kind of burning sensation under the upper denture. It gets so severe in the late afternoon that she has to remove the dentures. If she continues to wear them through the day, her mouth will break out in little blisters. She does not complain of the lowers.

Before we made the dentures her tissues healed slowly and the ridges did not round off as they ordinarily do. She also complained of a very severe burning sensation. Where should we look for the cause?—E.F.F., D.D.S., Nebraska

A.—A burning sensation in the mouth is usually caused by nerve pressure, nearly always upon a nerve trunk as it emerges from one of the foramina but occasionally it may be from negative pressure or suction upon such a nerve trunk, or on certain hypersensitive nerve endings or fibrils.

If you can locate, with finger pressure or with pressure with a large round burnisher, a point where pressure causes the burning sensation, cut out the plate liberally for relief over this area. If the burning sensation continues, fill this space with soft wax and let the patient wear it so for a day or two. If the burning sensation is relieved, the denture should be refitted to this form.

Among other possible causes or contributing factors that should be considered are: the habitual use of some drug or drugs, a residual area of infection in the bone, allergy or protein susceptibility or the use of too strong mouth washes or dentifrices.—V. C. SMEDLEY

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EFFECT OF ROENTGEN-RAY AND RADIUM TREATMENTS

Q.—I made a three-quarter preparation on an upper right second molar on a man, aged 40, with the idea of making slice preparations on all the posterior teeth to open the bite slightly and bring the teeth into balanced occlusion. The tooth was quite sensitive and I used novocaine keeping the tooth cool, during the preparation of the cavity, with a stream of water. Before dismissing him I placed a splint from the third molar to the first bicuspid with temporary cement. The lingual surface was left partly exposed.

Thereafter, about twice a day, he had a dull pain in the tooth lasting from fifteen to thirty minutes. A

week later the tooth was so painful I tried to treat it with eugenol and other agents but, as soon as any one of them touched the tooth, even as a warm application, it would begin to ache intensely. I finally covered the tooth with a thick covering of zinc oxide and eugenol with a few cotton fibers to hold them together. The pain lasted almost an hour.

Since then it has bothered him about twice a day as before and sometimes he is awakened at night by it. I am wondering if radium or deep roentgen rays could have affected the nerve in this tooth as he has had radium planted in a recurring tumor involving the parotid gland on this side. The radium has been in now for about three months and he has had three roentgen-ray treatments in the last two months. He has also had three operations for the removal of this tumor in the last four years.

I have already prepared the first and second bicuspid on this side and the third molar. I plan to remove the first molar because of an involvement of the bifurcation. I have noticed that the teeth on this side are more sensitive to work on than on the left side. I have made roentgenograms of all the teeth and their appearance is good, with the exception of the upper right first molar.

Do you think, if this tooth is left alone, it will gradually get better and be safe to keep?

I should mention, also, that the preparation is a shallow one scarcely through the enamel and the tooth was only slightly abraded. Moreover, this is the only tooth so far for which I have had to use novocaine. The splints were carved on the adjustable articulator and I am quite sure there is no traumatic occlusion.—H.D.L., D.D.S., Minnesota.

A.—The statements I am about to make are on the authority of a physician who limits his practice to the therapeutic use of the roentgen ray and radium.

The biologic effect of the roentgen ray on soft tissue begins at once and rises for about a week and then diminishes slowly for about three weeks. Whereas the effect of radium is negative for about a week and then rises for from nine to twelve weeks. The effect of the roentgen ray on the bone lasts for several years and, during that time, it is low in reparative powers and develops osteomyelitis with comparatively slight provocation. Here is a case in point. A man was treated for a malignancy of one side of the mandible with the roentgen ray. Six years later a tooth was extracted when he immediately developed an osteomyelitis which finally necessitated the removal of that half of the mandible.

You apparently worked on the second molar tooth while the pulp was still congested from the roentgen-ray and radium treatments. This tooth seems to have been affected more than the third molar or biscupids. The only thing to do now is to continue treating the second molar to correct the hyperemia.—GEORGE R. WARNER

ABNORMAL FRENUM

Q.—A patient, a boy, aged 22 months, has an abnormally large labial frenum that holds the upper central incisors 3 millimeters apart. Is resection of the frenum indicated?

Is resection of the labial frenum ever indicated before the eruption of the deciduous teeth?—I.W.W., D.D.S., Michigan.

A.—An abnormal frenum should never be severed until the permanent centrals are being brought together after their complete eruption. The scar tissue as the wound heals, after the centrals are brought together, may help to retain them. But if the frenum is severed before the eruption of the permanent teeth the scar tissue will interfere with their ever being brought into correct position.—V. C. SMEDLEY

"DEAN OF AMERICAN DENTISTS" PRACTICES IN WORCESTER

To Doctor C. Frank Bliven, Worcester, Massachusetts, goes the title of "Dean of American Dentists", according to an illustrated feature story of unusual interest that appeared in the Worcester *Sunday Telegram*. Oldest practicing dentist in the United States, Doctor Bliven has been working for almost sixty-five years and still carries on at 83.

Before the days of dental schools, he was apprenticed in 1869 to a dentist for three years. There he recalls performing what he believes was the first oral prophylaxis ever done in this country, when he spent a day and a half cleaning a young girl's teeth—taking time off to make the instruments he used for the work.

A pioneer in the true sense of the word, Doctor Bliven started to practice in Worcester in the early seventies just as "things began to move" in dentistry. He remembers the first use of soft gold fillings and cohesive gold. Gutta percha came into use at that time as a certifier, and Doctor Bliven was one of those dentists who rigged up a baker in which he prepared porcelain for use on the teeth. Whenever he lacked the proper instruments for his work he invented new ones or improved the crude ones of the period.

As the head of various dental societies, author of many scientific articles, lecturer, and director of clinics, Doctor Bliven has been an important factor in the development of modern dentistry. Professionally, he has vision. He sees dentistry of the future as a field of preventive medicine which will have the power and scope to remove the necessity for dentistry as it is practiced today. He thinks that both environment and climate, as well as the state of mind, affect the health of the teeth.

"I do not agree with anything you say, but I will fight to the death for your right to say it."
—*Voltaire*

RED MEDICINE DISCUSSED

I have just read Doctor P. T. Swanish's[1] review of RED MEDICINE by Sir Arthur Newsholme and Doctor John A. Kingsbury, which appeared in the March issue of ORAL HYGIENE.

A fact which tends to refute the reviewer's violent denunciations is that, of the many reviews of RED MEDICINE published approximately to date, only one other has been unfavorable. This appeared in the *New York Times* Book Review Section. It was by a Doctor Koiransky, apparently a White Russian with an obvious bias. From the venomous tone of Doctor Swanish's criticism, one who has read the book impartially feels that he, too, has a strong prejudice against anything coming out of the new Russia. He has completely failed to give an idea of the real quality of the book, or the avowed reasons for its publication. Several commentators of international fame, such as the late Doctor Wm. H. Welch of Johns Hopkins, have praised the book unqualifiedly. In a letter to the *Times*, which appeared a few weeks after Doctor Koiransky's unfair review, Mr. Kingsbury stated:

"It must be admitted by many well-informed persons, as it has been to me by many White Russians, that medical care in Czarist Russia was available only for a small minority; now —in the towns of Russia—no informed person will deny that it is available for practically all workers and is, furthermore, so coordinated that each worker has immediately available a medical service of consultants and hospital and sanatorium beds on an enormous scale, as well as of ordinary medical care. Nor does your reviewer give your readers any concep-

[1]Swanish, P. T.: Red Medicine, ORAL HYGIENE 24:370 (March) 1934.

tion of the vastly improved conditions of women and of infants and young children in respect to medical and hygienic care.

"The defects even in the present position are fully stated by us; but even if we give the fullest possible value to the Czarist figures given by your reviewer and compare them with our figures derived from the annual reviews in the League of Nations Year Book and from official Soviet sources, it is abundantly clear that there has been an almost incredible improvement. Some of your reviewer's figures carry their own refutation, and we say this as experienced statisticians.

"You are at liberty to publish this letter if you see fit, but we do not propose to burden your pages further than to express the hope that your readers will read RED MEDICINE and decide for themselves whether this volume does not convey a truth-like picture of a great national accomplishment, as assessed by two critical observers who have had many years of experience in public health administration."

This not only answers the Russian physician; it is in effect a reply to Doctor Swanish.

It happens that I, too, spent a month in the Soviet Union a few months after the authors had made their tour, and on somewhat the same mission, although with a different emphasis. (I was primarily concerned with the development of dental service and education.) I frequently found myself following in their footsteps. I had visited Russia twice before, in 1904 and in 1908. Both times I took opportunity to observe medical and dental conditions under the former régime. I may say from personal experience that what these men actually observed is ground enough for the conclusions reached. I have, moreover, the pleasure of knowing professionally both the authors of RED MEDICINE. They went to the Soviet Union with a wholly detached point of view. One of them, at least, I believe, was definitely skeptical of what he should find. That they returned with any enthusiasm for what they saw is an indication of probable understatement. A fair-minded man interested in the question will not be unduly influenced by a reviewer obviously writing with a strong animus against changed conditions. He will read the book and form his own judgment.—ALFRED OWRE, D.M.D., M.D., *Pine Plains, New York.*

P.S. The comment of a reviewer in the San Francisco *Chronicle*, Joseph Henry Jackson, is especially pertinent for medical and dental readers. Mr. Jackson writes:

"It's a book for every intelligent reader who is willing to admit that possibly some other country might have something to teach America. After all, if a kind of socialized medicine does eventually come about in America—and many think we are close to something of the sort—it is the voters who will

bring it to pass as much as the doctors. If you are a voter, then, this is a book you ought to know about."—A. O.

Editor's Note: Doctor Owre was the former dean of the College of Dentistry, University of Minnesota, and of the School of Dental and Oral Surgery, of Columbia University, New York City.

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ADVERTISING VS. ETHICS

I wonder if I, a dentist's mere wife, might voice an opinion in the controversy on Advertising vs. Ethics? As Doctor Ware[2] states in the March issue of ORAL HYGIENE, this country is advertising conscious. The dentist has a moral obligation to give his patient the best he knows how for that patient's health. As all dentists know, *if they will admit it*, students are passed through dental colleges better fitted to be brick layers—to whom a patient means simply a fee. If these men were advertising how long would it be before the public would realize that they are incompetent? If the public were educated by *dentists in what constitutes good dentistry*—these men instead of hiding behind the skirts of Ethics, where they fool an unsuspecting public for years, causing them to lose their own teeth, perhaps continuing the process up to the point of making them ill fitting plates, or else causing them to ruin their health through ill-fitting bridges or inferior restorations, would be exposed as fakers whose mischief is even greater than the so-called advertising men. The dentist who educates his clientele to know what he should have at fair prices is a public benefactor.

Advertising induces competition, and competition makes a man give the best he has. The *real dentist*—the one who knows his business—is not afraid of competition.

I am not a dentist, but I've often wondered at the Ethics which prevents a man from doing his duty in teaching an unsuspecting world that all dentists are not good dentists, merely because they are "placidly" ethical.—FLORENCE WOOD, *Taunton, Massachusetts.*

P.S. And to those who say—"But dentistry is a profession"—try eating your profession one of these days, Doctor ——. Unfortunately, meats and rents, etc., are still with us.—F.W.

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IS ESMERALDA RIGHT?

I have read Esmeralda De Mar's letter[3] in the April issue of ORAL HYGIENE. In the main Esmeralda is right. I thoroughly agree with her that the filling of a tooth is surgery, and that it should be done under some form of anesthesia; but two or three of her qualifying observations don't set quite right with me.

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[2]Ware, C. C.: Should Dentists Advertise? ORAL HYGIENE 24:391 (March) 1934.

[3]Who Should Prescribe Diet? ORAL HYGIENE 24:558 (April) 1934.

Firstly, that dentistry has stood still while other branches of medical science have bounded merrily forward. Maybe I've been looking through the wrong end of the telescope for the last few years, but it does seem to me that dentistry has crept ahead a bit, not only in technique, but also in the attitude of men practicing it. If that were not so there would not be so much talk about cooperation with the physician in the treatment of disease, or such lively interest shown in the theory that serious metastatic disturbances can emanate from a focus around a tooth.

Secondly, what practical methods other than cataphoresis, analgesia, or novocaine injection can we hope to use? General anesthesia with the mouth wide open? It is to laugh. Or does Esmeralda expect us to use spinal anesthesia or twilight sleep in a dental office? The Lord only knows dentistry is expensive enough to practice without making a hospital job of it.

Thirdly, where are the competent physicians who understand dental anesthesia? The medical profession, for better or worse, Esmeralda, left the teeth and their supporting structures to us. And, without bragging too much, I might say we have gotten to understand them pretty thoroughly in the last seventy-five years. More power to those earnest medicos though! We will welcome them with wide open arms.

To be serious though, cavity preparation should be done under an anesthetic. Novocaine, especially since the discovery of Cobefrin, which does away with many of the objectionable qualities of suprarenin or adrenalin, is quite adequate. It is safe, requires no involved technique, and will provide all the anesthesia any reasonable patient would demand.

An article in ORAL HYGIENE on this subject would not come amiss, especially if it were written in a light and gladsome vein. There's too damn much ponderous thinking in most of our professional articles.—FRANK ENTWISTLE, D.D.S., *Lynbrook, New York.*

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"ANXIOUS-TO-KNOW" WRITES IN

I am just a young boy, thirty-seven years old, and I wonder if you still give advice to the care-worn. Now, f'rinstance, a year ago a lady came to me to have a couple of teeth extracted on time. She didn't say how much time, but I know now she meant at least one year, mebbe ten. She said, "I wanted to go to Doctor Pulz down the street, on account I think he is better, but I didn't have the money, and I knew you better so I came to you." Should I have tripped her at the head of the stairs as she left, or did I do right by smiling like a constipated cat and assuring her it would have to be all right?

I always get cash for prosthetic work. So do all the other boys. They told me so at the last dental society meeting. But

suppose the rent is due, and the supply house is sending very personal letters with genuine autographs of the credit manager, and then Mrs. McGouigle comes in from the country with $17.37 she has saved from egg money and tells you she's decided to have that full upper and lower she thought she'd get last year; that she'll pay the balance next fall, or "ennyhow by spring." What would you do, Uncle Oral? That's what I do, too.

Before I close for this time, hoping you are the same, I want to verify a rumor. I know you disapprove of hearsay and gossip, but I've heard that the dentists of this country spend approximately one-third of their productive time doing work that produces no revenue, such as make-overs, denture adjustments, re-filling, postoperative treatments, and listening to the story of how Uncle Horace was in the chair two hours getting his back jaw tooth dug out in eighteen pieces. It had three prongs and was wrapped around the jawbone.

I know I can buy any number of beautifully bound, genuine calf-skin volumes on Dental Economics on easy payments, but what I wanta know is this: Do the majority of dentists charge Uncle Horace for postoperative treatments, or do they consider them part of the fee for extraction? And do they sometimes feel a bit guilty, even when they've done the very best they know how to do? I want to do right, Uncle Oral, both by myself and the suffering public.

I will not perplex you further, dear Uncle, but you have been so helpful to me and many others, I just thought I would write, for I am Anxious-to-Know.—H. S. COLDIRON, D.D.S., *Columbus, Kansas.*

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WHAT ABOUT THE CLINICS?

Dentistry in general is a wonderful and most necessary profession. When we start to care for the teeth at an early age and really take care of them, we can do much to prevent disorders of the masticatory organs. Preventive dentistry is the important thing nowadays. Yet, does any one realize how many dentists are sitting around idle, not because of the depression, but on account of the clinic evil?

Not far from where I am located, there are two hospitals. One charges fifty cents for extractions; the other has no charge. Many patients whom I know can afford to pay for services avail themselves of the hospitals' services. The pay clinic does other work, such as making plates, bridges, and so on. Many patients who go there are not investigated as to their financial standing.

I have read articles on clinics, but no one of influence in the profession has, as yet, tried to do something regarding them.—L. LEVY, D.D.S., *354 Gold Street, Brooklyn, New York.*

What about the DENTAL CLINIC?

The Kings County Clinic Report

By MICHAEL PEYSER, D.D.S.

THE final report of the Committee on the Costs of Medical Care has demonstrated clearly to every dentist, whether that dentist practices in a rural or urban area, the inevitability of a revolutionary change in our present system of health service. Those who ignore recent trends and belittle the conclusions of careful investigators are deluding themselves.

In what precise forms these changes will occur nobody can foretell. But a change will occur, everyone must admit. The probability is that one of the changes will be toward a form of group practice. The old single practitioner's office is doomed. On this, all competent authority is in agreement.

All serious and sincere students of the economics of health service are unanimous in their conviction that the profession must make a thorough investigation of its own into all phases of the problem, in order that it may more thoroughly understand and be prepared to deal with the matter in the future.

Having this in mind, the Kings County Dental Society of Brooklyn, New York, one of the nine component societies of the Allied Dental Council, asked a group of their own members, under the leadership of Doctor Paul Greenberg as chairman, to undertake a thorough investigation of all the dental clinics in Greater New York.

The start was made with the dental clinics because it was immediately apparent to everyone that we already have group practice in our midst in the form of these very same clinics. The committee, therefore, was very properly called the Dental Clinics Committee.

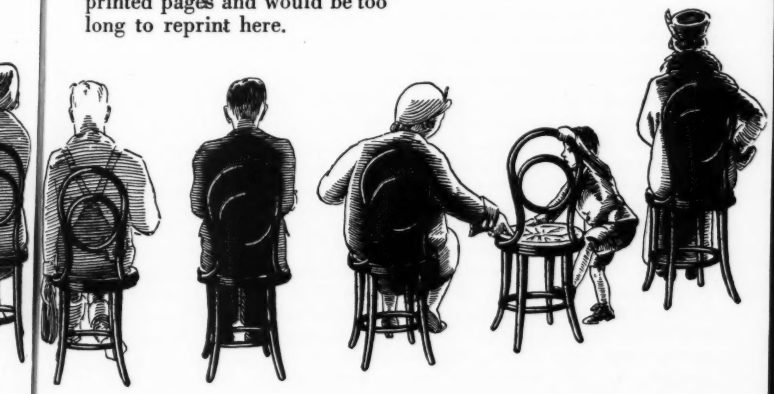
This committee has been at work for two years and on November twenty-first of last year made its report and recommendations. These were accepted by the society which passed a resolution to that effect. This paper will briefly describe the important points in this report which takes up nine printed pages and would be too long to reprint here.

The readers from other states may pause here and inquire of themselves just what interest they each have personally in such a purely local matter. The writer hastens to assure all dentists that it behooves every one to study carefully the brief synopsis, analysis, and conclusions that will be given here.

NEW CLINICS ORGANIZED

New clinics are daily being promoted and organized in every state. Dental clinics cannot possibly function without dentists and, therefore, it is important for dentists to know something about dental clinics before they give their approval of, or promise cooperation with, dental clinics. The report of the Kings County Clinic Committee has a wealth of information and, more important, it has in it a world of implications.

Under the title of *The Evolution of The Dental Clinic,* the report says:



"The dental clinic was originally, and still is in many cases, but a small part of a general medical dispensary, usually attached to a hospital. Years back, because of the great number of people who came to these clinics with dental ailments, it became necessary to institute some sort of distinct dental service. At first it was, what may be termed, 'emergency dental services to the poor.' It relieved toothaches and reduced swellings. The fees were very small, usually ten to twenty-five cents, just for registration. The distinct purpose of these clinics was to give medical, dental, and surgical relief to those poor people who could not otherwise obtain it. Restorative dentistry was not even dreamed of, except at the college clinic. Gradually, more and more dentists were employed in these clinics and these operators were anxious to make a good showing. They took a just pride in their work and sought to elevate the status of their profession and also earn the esteem of their fellow co-workers, the physicians. As a result, these men wandered far afield from the simple 'emergency service' and extended their services to all branches of dentistry.

"This extension of the service was encouraged by the governing boards of the clinics. Today, we have such a well organized clinic system that any service from prophylaxis to the correction of malocclusion can be given. At the beginning, only the poor patronized the clinics, but as the scope of the service widened and became better, people who were not so poor came. This became so apparent that a special provision for them was planned. The clinics, feeling that these people could pay more began to charge more. At first it was doubtful as to whether self-respecting, middle-class people would come to a clinic and be charged for the services. These doubts were soon dispelled as these people did come. And, as a result, another form of clinic was evolved, the pay-clinic. These clinics give a complete service. They employ dentists at very low salaries, if any, and charge fees entirely out of proportion to what operators receive as compensation."

The question is then asked:

"Is the clinic idea popular with the public? During 1932 there were made to the free dispensaries of New York City 6,688,215 visits, compared with 4,183,933 visits in 1927, showing an enormous growth of clinic-minded patients within the last five years. According to the report of the United Hospital Fund, issued October, 1933, there were over 1,500,000 persons using the services of clinics and dispensaries, one in every four in the city, one-third of them paying nothing, two-thirds paying fees.

"Over 26 per cent of the city's inhabitants are seeking services in clinics and dispensaries, leaving the profession with less than three-fourths of the population as potential patients for practice...."

The committee was curious as to the income and expenses of these clinics, and here is what it found out. It is important to point out in this connection that no law in any state allows a clinic to make a profit.

"In the year 1932 the hospital members of the United Hospital Fund received from dispensary patients $2,299,268.00. The direct expense for the Out-Patient Department of these institutions was $1,965,144.00. Profit to the clinics $334,124.00. For the year 1931, the profit to the clinics was nearly one-half million dollars. These profits evidently are dissipated in high salaries to lay executives and in

overcoming deficits in other departments of the clinic."

To aid in grasping the magnitude of this problem, the following will be illuminating:

"There are in the City of New York 138 dental clinics and 95 medical clinics, distributed among the five boroughs as follows:

Manhattan	76 dental	56 medical
Bronx	17 dental	6 medical
Brooklyn	36 dental	27 medical
Queens	6 dental	4 medical
Richmond	3 dental	2 medical

To prevent a misconstruction of the committee's attitude, the following statement is made:

"While we are in sympathy with the plight of those who cannot take care of their health and must apply to charitable institutions for free relief of pain and suffering, we protest with all the power at our command against those clinics which accept patients who can well afford the services of a private practitioner.

"As long as services at clinics were limited originally to immediate alleviation of pain only, in the form of extractions and minor oral surgery, the competitive effects on general practice were not felt so drastically. However, with the inauguration in many clinics of orthodontia, operative, prosthetic, and other departments wherein services are rendered in practically all branches of dentistry, the effects on the general practitioner were so devastating, as to be barely short of catastrophic."

Since pay-clinics are being advocated so much by health economists, especially Michael Davis of the Rosenwald Foundation, the committee says the following, keeping in mind the New York State law, which is practically the same in many other states:

"Under what theory, considering the spirit of the law, a pay-clinic is able to operate, is one of the mysteries this committee has not yet solved. For in these dental pay-clinics, patients spend as much or even more than they do in a private office. . . ."

Here is something interesting:

"It is common knowledge that 50 per cent or more of the patients in clinics are not entitled to the service. It is well known that the clinics do not live up to the rules on this point. It is equally common knowledge that the indigent, for whom the dispensaries are intended, are crowded out by those who can pay the clinic fee. In other words the deserving poor for whom the dispensaries were really established are crowded out as a result of a policy, practiced by the clinics, that each patient must pay his or her way through the dispensary and those who can pay get the preference to the exclusion of the others who cannot pay."

Davis and other health economists always prate about self-supporting pay-clinics. They are supposed to have made careful investigations. Do they know or have they deliberately ignored the following?

"It is also clear in the law that clinics are intended to be supported by trust funds, contributions, etc., which are supposed to pay the greater part of the maintenance of the clinic. We all know this is not done. The policy followed at present is to make the clinic self-supporting, which is of course against the law. There is a great suspicion that a lot of clinic money is spent in paying out high salaries and for other purposes not called for in the rules."

The writer emphasizes here again that the law in many states on this point is the same

in effect as the New York State law.

In summing up some of the findings, we see that the original conception and purposes of the clinic have been prostituted. The clinics were intended to give emergency surgical treatment to worthy indigents. Instead they give all sorts of services, ranging up to deluxe restorations, to all sorts of people from the indigents to the well-to-do. The clinics, instead of being truly charitable, have striven to get into the "business of health service" and then make that "business" self-supporting or even profitable. Clinics are generally promoted by lay social service workers, and these workers seem to be ignorant of, or are not concerned with, the economic consequences of their endeavors to the private practitioner. The clinics are licensed by law and are presumably operating under certain rules and regulations. The evidence in the city of New York shows clearly that the letter and spirit of the law, rules, and regulations are being violated. The writer can rightfully presume that this is also being done in other large centers.

Now that you know the story of the situation in the city of New York what will you dentists do about it, when in the future you are called upon to help organize or cooperate with a new dental clinic?

It would be foolish to oppose dental clinics when there are so many who need dental services and cannot afford to pay private practice fees. Therefore, your duty as a dentist almost compels you to cooperate and, if you do, insist that:

1. Those who organize the clinic should have a good knowledge of, and actually possess the will for, real social service.

2. The clinic be properly financed. That through trust funds, private and public contributions, there should be on hand enough money to take care of all overhead expenses, such as rent, light, heat, incidentals, and all the expenses of maintaining an investigation department.

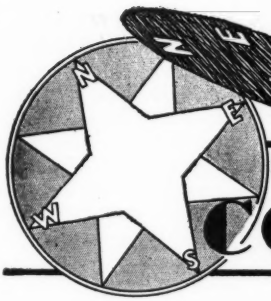
3. There be established such a social service department, which shall certify after thorough investigation the eligibility of each applicant for service. Of course, those who need immediate service should be given it without investigation.

4. The service of a dental clinic be strictly limited in scope. In general the limitation may be described as "service sufficient to promote and maintain the health of the patient."

5. If fees are charged and these fees are above the actual cost of materials, the operator should receive two-thirds of the fee as a recompense.

6. A complete set of books be kept, to make the relation between expenses and income definitely clear, and to the end that all salaries paid be definitely disclosed. If the dental clinic is a part of a general clinic, separate books should be kept, in order to disclose if profits made in the dental clinic are spent in support of other departments. This should not be allowed. The Kings County Committee reports this as one of the evils in the large dispensaries in New York.

219 Jamaica Avenue
Queens Village, Long Island, N. Y.



The Dental COMPASS

URGES FEDERAL AID FOR PREVENTIVE DENTISTRY

More than 250,000 dental cases have been treated without fee in New York State through the activities of the Federal Emergency Relief Administration, Doctor John T. Hanks, chairman of the state dental advisory committee, told the First District Dental Society in a recent address at the Academy of Medicine. A total of 129,603 visits to dentists have been made by 31,000 patients in this city, Doctor Hanks said.

He urged amendment of FERA regulations to permit preventive and restorative dental health service, as well as emergency treatment, for persons on relief rolls. Doctor Hanks rejected the suggestion that extension of such treatment might tend toward the socialization of dentistry on the ground that the patients cared for by the government would never otherwise seek professional care.

Doctor Hanks recommended that the fees charged the government by dentists for emergency relief work be kept "sufficiently low so that funds available for dental service will go as far as possible and so that taxpayers will not complain." He added that the maximum fees for relief cases should be adjusted to meet the minimum in ethical private practice.

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PAINLESS DENTISTRY KNOWN TO MEXICAN INDIANS

Painless dentistry was practiced by the Zapotec Indians in Mexico 1,000 years ago by the use of a natural anesthetic, a wild mushroom, which produced a "jag" that lasted for days. This fact was brought to light in a recent interview with Professor Marshall H. Saville, archaeologist of Columbia University, at the American Museum of Natural History.

As evidence, Doctor Saville displayed a number of ancient teeth dug up by him more than

thirty years ago in Zapotec tombs near the city of Oaxaca, in Mexico. The teeth were beautifully inlaid with hematite and other metals, the workmanship so perfect that the most up-to-date dentist could do no better.

Such workmanship, Doctor Saville pointed out, could not have been accomplished without the use of anesthetics. Even the most Spartan of Indians could not have stood the pain with sufficient fortitude to allow for the evenness and perfect proportions of the drilled cavities. Some of the teeth were found to be inlaid with gold and other precious metals. All the dental work was done solely for decoration.

In addition to the wild mushrooms, Doctor Saville said, the Indians also had such stupor-producing substances as peyote and marihuana.

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PROMINENT DENTIST APPROVES KISSING

Speaking from a technical standpoint, kissing was officially approved by a prominent dentist at the annual convention of the California State Dental Association.

"There are germs in every mouth," said Doctor Thomas B. Hartzell, chairman of the American Dental Association's research committee and former president of the association. "But," he added "you'll find the same germs in all mouths—the girls' as well as the boys'."

PENNSYLVANIA DENTAL SURVEY COMPLETED

In accordance with a plan instituted by the United States Government to conduct a dental survey of the grade school children of the nation for the purpose of determining the general condition of the mouth and teeth, the American Dental Association has been making this important survey through its component societies, one of which, the Pennsylvania State Dental Society, has recently reported the completion of its survey in that state.

On account of the great number of schools in Pennsylvania, full mouth examinations of 10 per cent of the grade students were deemed sufficient for arriving at the general condition of the teeth.

That this survey is of the utmost importance as a means of emphasizing the necessity for periodic dental examinations is indicated by the following report of general dental conditions found among the Clearfield, Pennsylvania students:

Number examined	749
Extractions indicated	692
Fillings indicated	2,161
Cleaning indicated	656
Slight irregularities	159
Extensive irregularities	25
Diseased gums	15

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DENTIST'S HOBBIES RANGE FROM GOLD BUGS TO SHIPS

The hobbies of Doctor J. P. Bell, a dentist of Baltimore, Maryland, cover a range wide

enough to include gold bugs and motor boats.

In odd moments he is a sculptor. Sometimes he casts delicate flowers in gold, ornaments walls, and makes fish pools for his wife. At other times, he originates models of streamline automobiles and builds speed boats.

These automobiles, with even the handles of the doors hidden from wind resistance, are modeled in clay, then cast in plaster. They are designed, Doctor Bell says, more for comfort than for speed, although their smooth construction automatically means increased speed.

In his office are delicate casts of lilies of the valley, centipedes, house flies, and a four-leaf clover. Taken in their natural state, they are encased in gold without so much as a hair-like leg or tender petal being injured.

His steady dentist's hands have reproduced in perfect detail a statue of Lafayette astride his horse. The reproduction is only seven-eighths of an inch high, while the original is nearly 10 feet. This miniature sits in the case in his office flanked by a pair of boxers in sparring position, delicately poised dancers, fighting cocks, and muscular athletes.

Doctor Bell has coached the University of Maryland Dental School ice hockey team and once made his living playing professional hockey.

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BRONX DENTIST EXHIBITS PAINTING

"Whither? A Modern Allegory," a painting by Doctor W. Avstreih, a Bronx dentist, was put on view at the Grand Central Palace April 13 as part of the Independents' Art Show. A shirt-sleeved figure, representing modern man is shown trampling culture, typified by a prone woman and scattered books and papers. His struggles in his mad pursuit of riches and the pleasures wealth can buy, according to the picture, lead only to death and oblivion, which are illustrated by the grinding of his bones to powder by a withered old woman. At the right of the man, a woman dressed in red points to a map of Russia and attempts to bring Communism to his attention.

POSITIONS FOR DENTISTS

Several positions are now available on the dental staff of the Outpatient Department of the Coney Island Hospital, Department of Hospitals of New York City. Applicants must be dentists registered in New York State and members of the American Dental Association. The position of dental externe, for one year commencing July 1, 1934, is also available. Please address communications relative to positions to John F. Wahlers, D.D.S., Williamsburg Bank Building, One Hanson Place, Brooklyn, New York.

LAFFODONTIA

If you have a story that appeals to you as funny, send it in to the editor. He MAY *print it—but he won't send it back.*

Film Star (newly married): "And is this your home?"

Bridegroom: "It is, precious."

Film Star: "Say, it looks mighty familiar. Are you sure we haven't been married before?"

No. 1: "I only worked three days last week."

No. 2: "Gee! I wish I could find a steady job like that!"

"Officer, you'd better lock me up. Jush hit my wife over the head with a club."

"Did you kill her?"

"Don't think sho. Tha'sh why I want to be locked up."

WANTED — Stenographer for heating contractor's office.

Mistress: "What beautiful scallops you have on your pies, Mandy! How do you do it?"

Cook: "'Deed, honey, dat ain't no trouble. I jes' uses my false teeth."

Jones had occasion to reprimand his wife. "I think, dear," he said soothingly, "that you fib a little occasionally."

She immediately became indignant.

"Well, I think it's a wife's duty," was her response.

"Wife's duty?" he echoed, wondering what was coming.

"Yes; to speak well of her husband occasionally," came the reply.

Patient: "Doctor, are you sure this is pneumonia? Sometimes doctors prescribe for one thing and patients die of something else."

Doctor (with dignity): "When I prescribe for pneumonia, you die of pneumonia."

"Why do you close your eyes every time you take a drink?"

"My doctor said I must not look at liquor."

A women walked into a shoe store for a pair of shoes. The salesman seated her and after taking her size said:

"One of your feet is so much larger than the other."

She left in a huff, and walked into another shoe store. The second salesman said:

"How much smaller your one foot is than the other."

She bought two pairs of shoes.

Landlord (to prospective tenant): "You know we keep it very quiet and orderly here. Do you have any children?"

"No."

"A piano, radio, or victrola?"

"No."

"Do you play any musical instrument? Do you have a dog, cat, or parrot?"

"No, but my fountain pen scratches a little sometimes."